CIARAN MCHALE BA (Hons) PGCert

ENGAGING IN GROUP THERAPY FOR DISTRESSING VOICE HEARING

Section A: What occurs during group therapy for mental health problems that relates with engagement? A narrative literature review using a systematic search methodology.

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Section B: Building a grounded theory of engagement in group person based cognitive therapy for distressing voices.

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Summary of the MRP Portfolio

Section A: Presents a narrative literature review using a systematic search methodology of research on in-group correlates of engagement in group therapy for mental health problems. Engagement is defined broadly, qualitative studies and those investigating dropout, attendance, homework and exposure task compliance, and "engagement" as defined in group climate research, are reviewed. Clinical recommendations include, particular support for patients at risk of drop out late in therapy and attending to the needs of the group-as-a-whole. Research implications include, the need for further qualitative work, experimental designs, multivariate designs and agreement upon operationalised definitions of key constructs.

Section B: Presents a study where grounded theory method was employed to build a theory of engagement in group person based cognitive therapy for distressing voices. The theory hypothesises a recursive process of investing in change and continually evaluating its usefulness and safety. Barriers are often overcome through individual and group efforts but sometimes perceived safety is compromised, leading to drop out. Incorporating learning from the group into life leads to rewards, some of which are integrated beyond group termination. The results are discussed in relation to theory including expectancy-motivation and the risk-responsibility model, and clinical and research implications are drawn out.

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SECTION A: ENGAGEMENT IN GROUP THERAPY FOR MENTAL HEALTH PROBLEMS

MAJOR RESEARCH PROJECT

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Section A: Literature Review

What occurs during group psychotherapy for mental health problems that relates with engagement? A narrative review of the literature employing a systematic search methodology.

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Abstract

The use of group therapies has been called for to extend access to psychological therapies. However, poor engagement with group therapy is common and has a detrimental impact on outcomes. Research on pre-therapy correlates of engagement has produced inconsistent results. The present narrative review sought to identify research on in-group correlates of engagement in group psychotherapy for mental health problems. A systematic search of Psychinfo, Medline, CINAHL and Social Policy and Practice from inception to January 2017 identified 30 papers that met inclusion criteria. Shorter groups may benefit from accelerated engagement but there is no evidence that therapeutic modality affects overall engagement. Several early therapy variables may predict later engagement. Cohesion and various leader interventions were found to improve group engagement. The research was limited by lack of agreement upon operationalised definitions of key constructs and a predominance of correlational designs precluding causal inferences. Future research should address these issues and employ qualitative and multivariate methods to investigate the complexities of group processes. Clinical recommendations include the use of outcome measures to guide group therapists, particular support for clients at risk of drop out late in therapy and attending to the needs of the group as a whole.

Keywords: Group psychotherapy, engagement, dropout, literature review.

Introduction

What is Engagement?

The concept of "engagement" in group therapy has been studied more often and recently in the forensic literature than in mental health literature. The group engagement measure (GEM) (Macgowan, 2006), widely used in the forensic literature, defines engagement broadly. It consists of five dimensions: attendance, contributing, relating, contracting and working. By contrast, research on group engagement in mental health has generally focused more narrowly on drop out or session attendance. Research interest in this area also seems to have diminished with time. The present systematic search found two reviews of drop out from group therapy for mental health problems published in 1987 alone (Bostwick, 1987; Roback & Smith, 1987) but none since then. Other indices of engagement in the mental health literature include compliance with exposure tasks in behavioural therapy (Hand, Lamontagne & Marks, 1974) and homework compliance in Cognitive Behavioural Therapy (CBT) (Woody & Adessky, 2003).

In contrast to the group dropout literature, the concept of "group climate" has been studied relatively extensively and recently in mental health literature. See Bakali, Wilberg, Klungsøyr and Lorentzen (2013) for a recent review. MacKenzie (1981) constructed a developmental model of psychotherapy groups and described how group climate differs with time as various developmental tasks are tackled. MacKenzie operationalised group climate, positing three dimensions, as measured by his group climate questionnaire (GCQ): engagement, avoidance and conflict. Thorgeirsdottir, Bjornsson and Arnkelsson (2015) define these concepts as follows:

"Engagement reflects a positive working atmosphere where members self-disclose, confront, care about and support one another. Conflict captures anger, distrust, and rejection

in the group and avoidance measures withdrawal and avoidance of personal responsibility for group work as well as dependence on the leader for direction." (p.203)

This literature review will include studies that measure the 'engagement' and 'avoidance' dimensions. Miles and Kivlighan (2010) describe productive groups as those "characterized by more engagement and less avoiding" (p. 115). By contrast MacKenzie's model (1983) allowed that groups: "may be simultaneously engaged and in conflict" (Bonsaksen, Lerdal, Borge, Sexton and Hoffart (2011, p. 33). Therefore conflict will not be considered in this review.

Given the above ideas, the definition of group engagement adopted in this review is:

"Attendance at group sessions and work on the tasks of group therapy as defined by the therapeutic modality under investigation."

This is a purposefully broad definition that admits an array of studies investigating different aspects of the work done in psychotherapy groups.

Why Study Groups?

Rising demand on mental health services internationally has led to calls for the increased use of group therapies to meet the shortfall in psychological therapy provision (Hellider, 2009; Paturel, 2012). Access to NICE recommended therapies in the UK remains limited, partly due to a lack of trained therapists (see Berry & Haddock, 2008 for example). A recent meta-analysis found format equivalence between individual and group CBT (Burlingame et al., 2016). Another meta-analysis of 23 studies found no differential benefit of individual or group therapy by diagnosis (McRoberts, Burlingame & Hoag, 1998). Group therapy also offers clients an opportunity to experience unique therapeutic factors not available in individual therapy, such as an experience of a social microcosm, universality,

cohesion (Yalom & Leszcz, 2005) and social learning (Bandura, 1961). Therefore group therapy is an effective option for increasing access to psychological therapies.

Why Study Engagement?

Dropout from psychotherapy is common. One meta-analysis of 125 studies found a mean dropout rate of 47% (Wierzbicki & Pekarik, 1993) with comparable dropout rates from individual and group therapy. Clients who terminate therapy prematurely report less therapeutic progress and more psychological distress (Pekarik, 1992). Poor attendance can also be a problem in group therapy. Unlike individual therapy, poor group attendance impacts on others; it can contribute to an "absence culture" (Gellatly & Luchak, 1998) and leave group members feeling insecure, worried, or angry (MacNair & Corazzini, 1994). The importance of group engagement extends beyond attendance. "Engagement" as measured by the GCQ, is moderately to strongly correlated with outcome (McClendon & Burlingame, 2010), while homework compliance in group CBT is associated with reduced symptom severity (Neimeyer, Kazantzis, Kassler, Baker & Fletcher, 2008).

Pre-therapy Correlates of Engagement

Research on group engagement initially focused on predicting group attendance given baseline characteristics, including: age (Chang & Saunders, 2002), socio demographic status (Klein & Carroll, 1986), education (Blackburn, Bishop, Glen, Whalley & Christie, 1981), depression scores (Persons, Burns & Perloff, 1988), and angry hostility and social inhibition (MacNair-Semands, 2002). Early research on psychodynamic groups focused on various "characterlogical defences" that might relate with later dropout (reviewed in Roback & Smith, 1987). However, this body of research has produced inconsistent results and replication failures. This is unlikely to be due to insufficient power to detect true differences. A meta-analysis aggregated samples from 125 dropout studies and found only a few variables – socioeconomic status, race and educational level – that were significantly related with

dropout. These produced small effect sizes and the authors acknowledge that their methodology, which excluded more studies with null findings, likely overestimated these effect sizes (Wierzbicki & Pekarik, 1993).

The effect of preparation for groups on engagement has also been investigated empirically. One study found a 13-30 % reduction in group dropouts with adequate group preparation (Piper, Debbane, Bienvenu & Garant, 1982). However, once group treatment begins none of this research adds to clinicians' ability to detect and rectify failing treatment (Mash & Hunsley, 1993) partly because it does not account for the role of variables at play during therapy. Therefore research attention has turned towards in-group correlates of engagement. A systematic literature search did not find any review of this body of literature. Given its potential clinical utility, at a time where more group therapy has been called for, this review will focus on this body of literature.

Aim

This narrative review employed a systematic search methodology to answer these questions: Are some therapies more engaging than others? Can we predict later engagement from early session variables? How can therapists and services maximise group engagement? The review aims to synthesise and critique literature investigating the relationship between in-group process and engagement in group psychotherapy for adults experiencing mental health problems. This review will not exclude studies based on the format of group therapy they investigate. Rather, as discussed above, one of the aims of the study is to compare engagement variables between formats.

A Note on Terminology

This review will follow the published literature in referring to participants who drop out of therapy as group "dropouts". While this language may seem objectifying, this is the

terminology unanimously used in the reviewed literature. For similar reasons "outliers" will be used to refer to group members who differ from their group in some relevant respect. This review will generally follow the particular paper under discussion when referring to group "therapists" or "leaders".

Method

Eligibility Criteria

This review sought to identify primary research that investigated processes occurring during group psychotherapy for mental health problems that relate to engagement. Please see Table 1 for inclusion criteria.

Table 1

Inclusion Criteria for the Systematic Search.

Inclusion criteria
Published in English
Published in peer reviewed journals
Primary research
Recruited adult participants only
Specified a research methodology that could be critically evaluated (e.g. clinical case descriptions were excluded)
Either (a) Recruited participants from mental health settings or (b) Verified participants from other settings meet DSM or ICD criteria for a mental disorder.[a]
Studied psychotherapy groups of any modality
Addressed group process in some way by either (a) measuring an independent or mediating variable hypothesised to affect engagement, after the beginning of a group (b) eliciting participants' experiences using a qualitative methodology after the beginning of a group or (c) comparing different group therapies with the explicit purpose of investigating differences in engagement. [b]

[a] In practice this meant excluding a large number of papers that researched groups focused purely on substance use, criminal behaviour and physical health problems as well as university samples. [b] In practice this meant studies that tried to predict later group attendance by measuring participant characteristics at baseline were excluded. As were trials that happened to report on dropout but were primarily conducted to test efficacy, not engagement.

Literature Search

Four electronic databases were searched in two separate searches both conducted on 12th January 2017. The date range used was from database inception until 12th January 2017. The Ovid Advanced Search tool was used to search PsychINFO, MEDLINE and Social Policy and Practice. A direct search of the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database was conducted separately (see Appendix A for full search strategy). See Table 2 for the search terms used. Google Scholar was also searched and reference sections of the included papers were checked for further relevant papers. This revealed three more papers, which were included. See Figure 1 for a PRISMA diagram depicting the search process.

Search Terms. A number of terms are used to refer to 'engagement' in the literature, many of which have other generic meanings. All these terms were included in the search but only titles were searched using these terms. It was decided that not limiting these terms to titles would have yielded an unmanageable number of results (4,445,480 for key words vs. 356,199 when searched in title only). Furthermore this review is concerned with papers where engagement is a central concern of the research.

Group psychotherapy was mapped to subject headings assigned by librarians and all related sub-ordinate terms were also used.

Table 2

Search Terms Used in the Review

Search terms combined with AND
engag* or dropout* or disengag* or climate or attrition or compliance or attend* or participat* or terminat* or continu* or absen* or complet* or dropping out or treatment readiness or lapsed or lapsing or defection or defecting (searched for in titles only)
group psychotherapy (mapped to subject heading and "exploded")

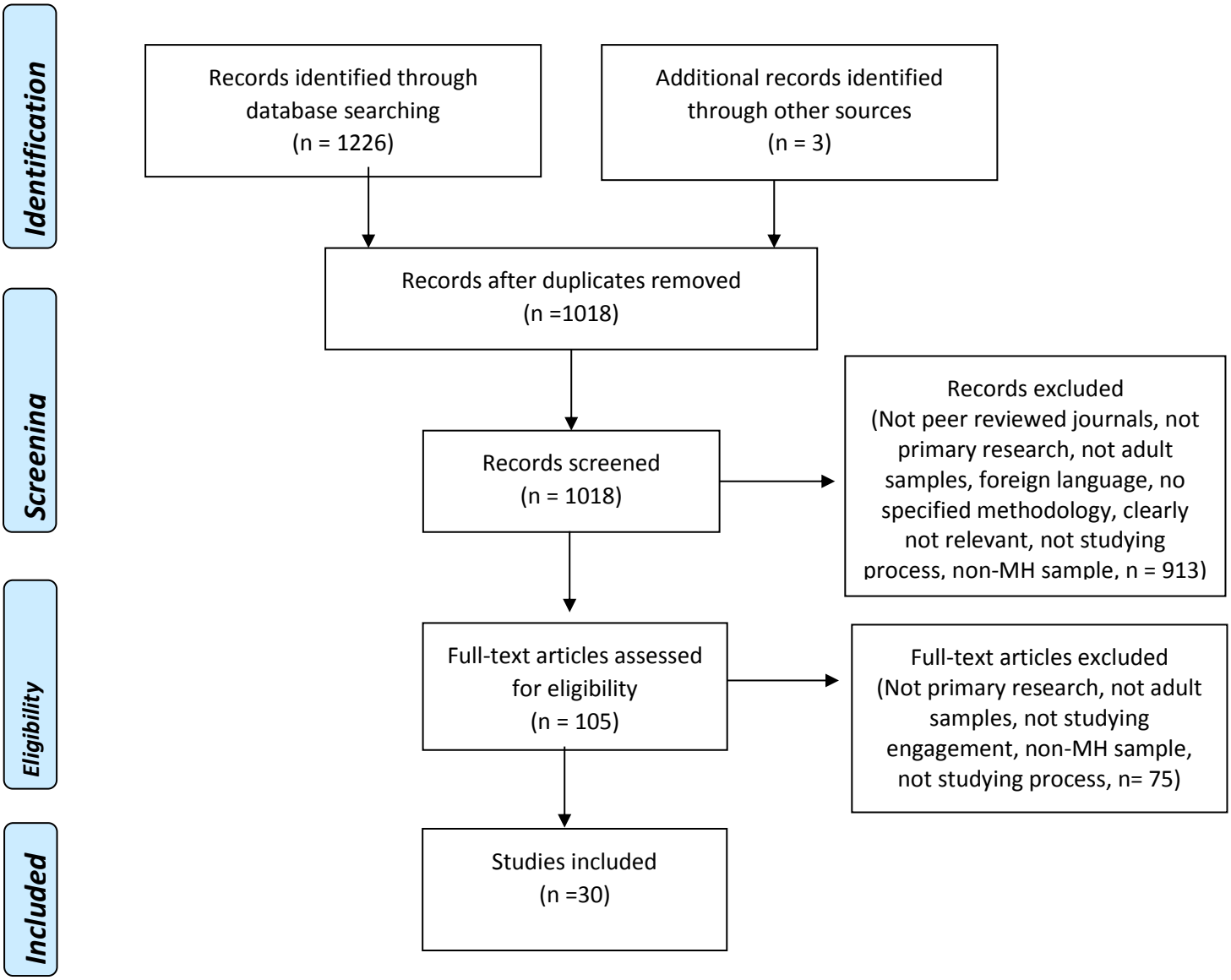

Figure 1. PRISMA diagram depicting search process.

3. Results

The systematic search yielded 30 papers that met inclusion criteria. As can be seen from Table 3, among the studies were: eight trials, seven with random assignment to conditions, one experimental alternating treatments design; six qualitative studies, five using no established methodology and one using Interpretive Phenomenological Analysis (IPA);

fourteen longitudinal observational designs; one observational cross-sectional design and two surveys reporting descriptive statistics. Two studies used a mix of the methods reported here.

Table 3

Study Characteristics

Author	N	Design	Treatment type and duration	Measure of engagement	Correlates of engagement
Bakali et al. (2013)	145	RT	20 week or 80 week psychodynamic group therapy	GCQ –engagement and avoidance	Less avoidance in short-term therapy.
Bernard & Drob (1989)	10	Qualitative.	Long-term psychodynamic groups	Qualitative data generated.	NA
Blake et al. (1990)	95	Experimental. Alternating treatments design.	Various inpatient groups.	Session attendance.	Between-session encouragement increased attendance.
Bonsaksen et al. (2010)	80	RT	10 week residential CBGT and IPT for SAD	GCQ –engagement and avoidance	No overall differences between therapeutic modalities
Carter et al. (1995)	31	Survey	Couples CBGT for panic disorder.	Dropout	Problems getting to treatment and dissatisfaction with CBT cited as reasons for dropout.
Chapman et al. (2010)	42	Qualitative	Long-term psychodynamic groups	Qualitative data generated.	NA
Connelly et al. (1986)	66	Observational. Longitudinal.	Long-term psychodynamic groups	Dropout.	Therapist and client ratings of cohesion
Delsignore et al.(2016)	91	RT	15 week CBGT for SAD.	Session attendance.	Between-session email contact increased attendance for an at-risk sub-group.

Gruen et al. (1977)	23	Observational. Longitudinal.	GPT	Observer-ratings of the group solving individual and group problems.	Leader anticipation of group themes and control of group discussion
Hand et al. (1974)	25	RT.	Flooding for agoraphobia.	Therapist rated application of behavioural techniques and self-reported phobic avoidance.	Group cohesion.
Joyce et al. (1988)	76	Non-randomised Trial.	Brief crisis groups and long-term psychodynamic groups.	GCQ –engagement and avoidance	Avoidance decreased more quickly in brief crisis groups
Kivlighan & Paquin (2014)	73	Observational. Longitudinal.	TREM groups for relational trauma, inpatient forensic.	Intimate behaviours.	Within member deviations in GCQ – engagement.
Koran & Costell (1973)	87	Observational. Longitudinal.	Outpatient. Long-term psychodynamic groups.	Dropout.	Failure to complete questionnaires predicted early dropout.
Mason & Adler (2012)	11	Qualitative. IPA.	Various inpatient forensic groups.	Qualitative data generated.	NA
McCallum et al. (2002)		Observational. Longitudinal.	Short-term groups for complicated grief.	Dropout.	Therapist rated cohesion and client rated positive affect at session one.
Murray et al. (1964)	9	RT	Inpatient groups.	Verbal participation.	Racial diversity.
Nash et al. (1957)	30	Mixed methods. Observational. Cross-sectional. Qualitative.	Long-term psychodynamic groups	Dropout.	Interpersonal effectiveness.

Oei & Kazmierczak (1997)	131	Observational. Longitudinal.	12 week CBGT for depression.	Dropout.	Therapist-rated client participation
Ogrodniczuk et al. (2006a)	72	Observational. Longitudinal.	Supportive therapy and interpretive therapy	Session attendance	Cohesion as a mediating variable in supportive group therapy.
Ogrodniczuk et al. (2006b)	139	Observational. Longitudinal.	Supportive therapy and interpretive therapy	Session attendance and dropout.	Cohesion as a mediating variable.
Paquin et al. (2013)	51	Observational. Longitudinal.	TREM groups for relational trauma, inpatient forensic.	Session attendance.	Convergence with group on climate perceptions.
Paquin & Kivlighan (2016)	73	Observational. Longitudinal.	TREM groups for relational trauma, inpatient forensic.	GCQ –engagement and avoidance	Early absences with improved engagement. Later with worse engagement.
Phipps & Zastowny (2016)	50	Observational. Longitudinal.	Various outpatient groups.	GCQ –engagement and avoidance	Leadership behaviours.
Stone et al. (1980)	42	Qualitative.	Long-term psychodynamic groups.	Dropout	NA
Stiwne (1994)	14	Observational. Longitudinal.	Long-term psychodynamic groups	Dropout.	Self-rated participation and number of therapist-client interactions
Tasca et al. (2006)	65	RT	GPIP and CBGT for BED	GCQ –engagement and avoidance	No overall differences between therapeutic modalities
Thorgeirsdottir et al. (2015)	45	RT	Eight week CBGT and GPT	GCQ –engagement and avoidance	Therapeutic modality unrelated to engagement
Weiner (1984)	100	Observational. Longitudinal.	Long-term psychodynamic groups.	Dropout.	Low ego strength associated with late dropout.
Woody & Adessky (2002)	53	Observational. Longitudinal.	Short-term CBGT	Homework compliance.	Cohesion and alliance unrelated to homework compliance.

Yalom (1966)	91	Mixed methods. Qualitative + descriptive statistics.	GPT	Dropout.	NA

Note. RT= Randomised Trial. GCQ= Group Climate Questionnaire. IPA= Interpretive Phenomenological Analysis. CBGT= Cognitive Behavioural Group Therapy. GIPT= Group Interpersonal Therapy. GPIP= Group Psychodynamic Interpersonal Therapy. GPT= Group Psychotherapy. BED= Binge Eating Disorder. SAD=Social Anxiety Disorder. NA=not applicable.

The review will be structured by posing various questions of the literature, as summarised in the aims section above. Relevant theory and critique will be integrated throughout the review and the main findings will briefly be summarised at the end of each section.

Are Some Therapies More Engaging Than Others?

This section reviews trials that compared different forms of therapy on measures of engagement. These include comparisons of, long and short-term groups and various therapeutic modalities.

Therapeutic modality. Three studies compared the developmental trajectory of group climate between therapeutic modalities. Group climate in these studies was measured using the GCQ short-form (GCQ-S) (MacKenzie, 1983). This measure consists of three dimensions – engagement, avoidance and conflict. As discussed in the introduction, this review is concerned with engagement and avoidance. Aspects of these dimensions might not transfer easily between modalities. For example one question in the GCQ asks whether: "The members avoided looking at important issues going on between themselves". This is probably more applicable to modalities that foreground interpersonal dynamics. That said, many of the items are likely to be relevant across modalities. Indeed there is evidence that engagement and avoidance as measured by the GCQ correlate with outcomes across modalities (McClendon & Burlingame, 2010).

See Table 4 for a methodological appraisal of the trials reviewed in this section using an adapted version of the Effective Public Health Practice Project (EPHPP) quality tool. The EPHPP has established content and construct validity and intrarater reliability (Ciliska, Dobbins & Micucci, 2004). Thorgeirsdottir et al. (2015) randomised students diagnosed with Social Anxiety Disorder (SAD) to Cognitive Behavioural Group Therapy (CBGT) or Group

Psychotherapy (GPT). The authors analysed their data using multilevel growth curve models (Singer & Willett, 2003) because their data contained repeated measures within participants, nested within groups. Multilevel models account for the interdependence of observations in the doubly nested data, and counteract the effects of inflated statistical significance arising from this interdependence (Kreft & de Leeuw, 1998). The authors found great heterogeneity between individuals and groups in ratings of engagement and avoidance over time. However, contrary to their hypotheses, they found no differences between conditions in engagement. Post-hoc analyses suggested there was higher overall avoidance in CBGT. However, participants in the CBGT group scored higher on the measure of SAD at baseline and this was not controlled for statistically.

Participants in the Thorgeirsdottir et al. (2015) study were recruited from a university campus. Therefore the results may not generalise to treatment seeking populations. Bonsaksen et al (2011) reported findings from a study of participants with a primary diagnosis of SAD who sought treatment at a national residential centre. The authors found that engagement increased linearly over time in CBGT but decreased linearly in Group Interpersonal Therapy (GIPT). They did not test for significant overall differences in engagement and avoidance, but the differences between the means in each condition were less than the standard deviations within conditions. This suggests, in agreement with Thorgeirsdottir et al. (2015) that mean engagement and avoidance ratings in group therapy for SAD may not differ depending on the treatment modality.

Tasca, Balfour, Ritchie and Bissada (2006) tested group climate differences between CBGT and Group Psychodynamic Interpersonal Therapy (GPIP) with a sample of 65 women completing treatment for binge eating disorder (BED). Data were excluded from participants who dropped out of each condition, which may have affected the results. That said, in

keeping with the other results just summarised, the authors found no differences in overall engagement and avoidance scores between conditions.

As suggested by the diverging trends in engagement in the Thorgeirsdottir et al. (2015) study, the broad equivalence in engagement between therapeutic modalities may disguise certain subtleties. For example, Ogrodniczuk, Piper and Joyce (2006b) found that among a sample of people diagnosed with personality disorders (PDs), those with lower interpersonal distress at baseline attended fewer sessions of supportive but not interpretive group therapy. This suggests engagement may differ between therapeutic modalities for certain subgroups.

To summarise, the studies reviewed here provide no evidence that therapeutic modality affects overall group engagement, as measured by the GCQ or session attendance. However, the overall sample sizes recruited by Bonsaken et al. (2011), Tasca et al. (2006) and Thorgeirsdottir et al. (2015) were 80, 60 and 45 respectively. These studies were likely underpowered to pick up small effect sizes of therapeutic modality on engagement. Therefore their null findings should be interpreted with caution. Furthermore, comparing overall engagement disguises different developmental trajectories in engagement between modalities and differences in how sub-groups engage with different modalities.

Table 4

Methodological Appraisal of Trials Comparing Therapies Using the EPHPP

Criterion	Thorgeirsdottir et al. (2015)	Bonsaksen et al. (2010)	Tasca et al. (2006)	Bakali et al. (2013)	Joyce et al. (1988)
Selection bias	The sample were all students diagnosed with SAD, the findings may not generalise to people with SAD more generally. No information available on numbers or characteristics of non-respondents.	The sample is likely to be representative of people seeking residential treatment for SAD. No information available on numbers or characteristics on clients not consenting to participate.	Men were excluded, as were women who completed less than half the group sessions. The sample were all Caucasian with a higher than average level of education. Therefore the sample may not generalise to people seeking treatment for BED.	The clients were recruited from outpatient mental health settings. No information was provided on those who dropped out before therapy.	The clients were recruited from outpatient mental health settings. No information was provided on those who dropped out before therapy.
Study design	Therapists and participants were randomised to conditions. No information provided on method of randomisation.	Participants were randomised to conditions. No information provided on method of randomisation.	Participants were randomised to conditions. No information provided on method of randomisation.	Participants were randomised to conditions. No information provided on method of randomisation.	Participants were a self-selecting sample in each condition.
Confounders	Participants in the CBGT condition were older with more severe SAD scores at baseline. This was not controlled for statistically.	No differences between conditions in age, duration or severity of SAD or scores on other clinical measures. Conditions stratified by gender.	No differences between conditions in age, bmi, marital status, education, income at baseline.	The groups were not compared on any variables at baseline. There may be confounding variables.	The BCGT participants were older, more likely to be male, more likely to be referred by a physician, score higher on measures of depression and psychosocial stressors and less

					likely to have a PD diagnosis.
Blinding	Independent assessors blind to treatment assignment completed the SAD measure. The others were self-report.	All measures were self-report. Independent group therapists were used in both conditions.	Measures that weren't self-report were completed by a psychologist blind to treatment conditions.	It is not clear if group therapists were blinded. Outcome measures were self-report.	It is unclear if group therapists were blinded to the aims of the study.
Data collection method	The measures were validated with clinical populations and shown to have good reliability. The Cronbach's alpha for the avoidance scale was poor (0.46)	Clinical measures and group climate measures were validated on clinical populations and shown to have good reliability.	All measures were valid and reliable in clinical populations.	All measures were validated on clinical populations and shown to be reliable.	Of the measures examined in this review, only the GCQ had established validity.
Intervention integrity	Treatment adherence was independently assessed and deemed high in both conditions. Contamination of GPT with CBGT techniques was assessed and no evidence of this was found.	Treatment adherence was independently assessed and model consistent differences in conditions were found, with satisfactory interrater reliability.	Adherence to therapy protocls was adequate, as measured by independent raters. There were no therapist effects for adherence to the protocols.	There was no measure of adherence to the therapy protocols.	There was no measure of adherence to the therapy protocols.

Note. Criteria adapted from the EPHPP quality tool (Ciliska, Dobbins & Micucci, 2004).

Joyce, Azim and Mora (1988) using a non-randomised design, compared the self-report on the GCQ of 76 outpatients during the first eight sessions of either Brief Crisis Group Therapy (BCGT) or long-term GPT. The authors did not aim: "to pit these forms of group therapy against one another" (p.4). Rather, since BCGT was specifically developed to achieve therapeutic effect in brief time-periods, the authors were interested in how quickly short-term groups could build engagement. They found that engagement increased more in BCGT by session eight, and avoidance was lower on average than in the first eight sessions of long-term GPT. Bakali et al. (2013) built on these findings by randomising 145 outpatients to short-term (20 sessions) or long-term (80 sessions) psychodynamic groups. The authors acknowledge that the modalities did differ, but less so than in Joyce et al.'s (1988) study. They found no overall differences in engagement between conditions. However, they found that avoidance decreased more quickly in short-term therapy.

Bakali et al. (2013) argue that their findings, taken with those of Joyce et al. (1988) suggest that time in group therapy is "relative", not Newtonian. However, we should exercise caution in drawing conclusions from these studies. Joyce et al.'s (1988) BCGT participants weren't randomised and Bakali et al. (2013) acknowledged their therapeutic approaches differed. Nonetheless these studies suggest that short-term group therapy benefits from an accelerated reduction in avoidance through some combination of: differences in clients' expectations and behaviour, therapist behaviours and the therapeutic modalities themselves. Future research should investigate the relative influence of these mechanisms.

In summary, the trials just reviewed provide some evidence that shorter-term groups experience an accelerated reduction in avoidance, though the reasons for this remain unclear. There was large variability in engagement between therapy groups, within the same conditions, in all the trails just reviewed. This variation has not been accounted for by the independent variables under investigation in these studies. This suggests that multivariate and

longitudinal designs are needed to illuminate the interaction of different variables over time in shaping engagement. A number of studies using such designs are now considered.

Can we Predict Later Engagement from Early Session Variables?

McCallum, Piper, Ogrodniczuk and Joyce (2002) investigated predictors of dropout in a sample of 139 clients attending either supportive or interpretive therapy groups. They found that after session one, imminent dropouts reported less positive feelings than remainers and therapists reported less cohesion to the future dropouts. These findings closely match those of Connelly, Piper, DeCarufel and Debbane (1986) who found that early in long-term psychodynamic therapy, future dropouts perceived less compatibility among clients, viewed the therapists and other clients' less positively, and therapists viewed these clients as less "significant" (to the group's development) and expected them to improve less. Oei and Kazmierczak (1997) investigated slightly different variables and found that therapists' ratings at some sessions, but not others, predicted subsequent dropout. The Bonferroni adjustment was used to control for the inflated possibility of a type one error given these multiple comparisons. It should be noted that each of these studies used correlational designs and there are various plausible causal explanations for their findings. Therefore further research is needed to test the mechanisms by which clients identified as "at risk" come to drop out of therapy. One possible explanation, involving therapist behaviour is discussed in section 3.4.1.

Yalom and Leszcz (2005) theorised that group outliers are at particular risk of disengaging from group therapy. In a study of outliers, Koran and Costell (1977) operationalised "compatibility" as correlation with one's group in self-report on the Fundamental Interpersonal Relations Orientation, Behaviour (FIRO-B) checklist (Schutz, 1958). They found no difference between future dropouts and remainers on this measure of compatibility. However, this may be because only seven of 15 dropouts agreed to complete the questionnaires. In a recent study, Paquin, Kivlighan and Drogosz (2013) analysed the

relationship between "person-group (P-G) fit" and session attendance in a sample of women in a prison hospital participating in trauma recovery and empowerment model (TREM) groups for relational trauma. They operationalised P-G fit as the agreement between participants in their ratings of group climate and measured congruence (static) and convergence (dynamic). They found that converging with one's group on ratings of conflict was positively correlated with session attendance. There was no such relationship for congruence. Convergence may be particularly important in early stages of group formation (as in the group studied by Paquin et al. (2013). This notion is supported by the only study to date of congruence vs. convergence in individual therapy, which found convergence predicted outcome (Kivlighan & Arthur, 2000). Paquin et al. (2013) point out that their study "highlight(s) the importance of examining group processes over time" (p. 105).

In summary, these findings suggest a range of variables manifesting early in therapy may predict later dropout, including clients' positive affect and perceptions of their group and therapists' feelings and observations. However, these correlational designs do not allow us to infer causality. Furthermore, changes in variables over time may offer a better predictor of outcome than single time-point measurements. This review will now consider how group engagement can be maximised.

How can Group Engagement be maximised?

Timing of interventions may be important. Different variables and interventions may have a different impact and meaning at different points in group development. MacKenzie (1983) integrated various theories of group development into a comprehensive four-stage group developmental model. Each stage is characterised by different configurations of engagement, avoidance and conflict as group members tackle various developmental tasks. Although MacKenzie's specific model has produced inconsistent results (see Bonsaksen et al., 2010), the studies reviewed above have demonstrated that group

climate does shift markedly over the course of therapy. Furthermore, the studies discussed below support the idea that groups react to different variables in different ways as they develop.

Paquin and Kivlighan (2016) analysed data from 73 incarcerated women participating in TREM groups, the same sample described earlier. The authors found, as predicted, that absences in the first third of group sessions was positively correlated with engagement and negatively correlated with avoidance. Conversely, absences in the final third of sessions was negatively correlated with engagement and positively correlated with avoidance. It's possible that early absences increased the mean engagement ratings through the loss of some participants' self-report. Also the TREM groups focus on traumatic experiences in later sessions. Perhaps these sessions are disproportionately avoided through absence and avoidant behaviours in-session. Given this, future research should test for this differential effect of group absences in other modalities.

Paquin and Kivlighan (2016) explained their findings with reference to previous literature, which argues that early absences produce a sub-grouping effect: 'we're the ones who turn up and engage, and they aren't' (Agazarian & Gantt, 2005). According to Yalom and Leszcz (2005) sub-grouping can improve cohesion, and risk-taking. Furthermore, once groups have formed an identity, causal attributions may centre more threateningly on group processes. Paquin and Kivlighan's (2016) findings also fit with earlier research by Stone et al. (1980) whose participants frequently cited emotional reactions to others dropping out as a reason for their own withdrawal in the later stages of therapy.

In summary, the reviewed studies provide evidence of the dynamic nature of important group variables. Absences and dropouts late in group therapy may be particularly damaging to the remaining group. Conversely, earlier absences may improve overall engagement through a cohering sub-grouping effect. However, these findings are

correlational. Intervention studies would permit more confident inferences about causality and might point to useful clinical interventions.

Factors outside group sessions. Some of the reviewed studies suggest that services should attend to factors at play outside group sessions in an attempt to maximise engagement. Participants in the reviewed studies cited practical concerns such as transport, scheduling conflicts, moving area and external stressors, such as relationship and occupational problems as reasons for dropping out of therapy (Carter, Turovsky, Sbrocco, Meadows, 1995; Koran & Costell 1977; Weiner, 1984; Yalom, 1966). These studies generally employed small samples, and categorised qualitative answers about dropout with no formal coding system to come up with these findings. Therefore we cannot infer how prevalent these reasons for dropout are in general.

Other extra-group factors relate to clients' experiences of the service context. Bernard and Drob (1989) interviewed participants who dropped out of group therapy. They didn't use an established qualitative methodology (see Table 5) but many of their participants reported feeling they were there to "make up numbers" and weren't cared for by their therapists. This fits with findings from Mason and Adler's (2012) IPA study, in which participants acknowledged the importance of recognition by staff in motivating their engagement.

Table 5.

Methodological Appraisal of Reviewed Qualitative Studies Using Elliot, Fischer & Rennie Quality Guidelines

Criterion	Bernard & Drob (1989)	Mason & Adler (2012)	Stone et al. (1980)
Owning one's perspective.	The authors present a review of relevant theories and describe their aim as discovering which: "factors described in the literature are most salient to the clients themselves" (p.13). They do not present their personal anticipations.	The authors acknowledge that they drew on the health belief model and were particularly interested in the impact of previous experiences of group work and clinicians on engagement. The authors do not discuss their personal anticipations.	The authors make no attempt to describe their theoretical orientations or personal anticipations.
Situating the sample.	The authors specify demographic information on participants, including employment and current treatment and describe the setting they were recruited from.	The authors specify the setting the participants were recruited from, their gender, and claim to have selected a sample representative of the prison wards in terms of engagement and diagnosis. However, they present no information on their sampling frame.	The authors situate the sample in terms of the clinical setting and participants' social class, gender, age and "disorders" characterised as "having neuroses or character disorders" (p.402).
Grounding in examples.	Only a few examples are provided to ground each theme and these didn't always seem clearly relevant to the theme presented. The authors report that they did not follow any systematic method to discover themes.	Several quotes were provided for each theme from a range of participants. The quotes were clearly relevant to the themes.	Only a very few quotes are provided. It seems no systematic analytic procedure was followed.

Providing credibility checks.	None were apparent. The authors ascribed themes together, not independently.	None were apparent. This was acknowledged as a limitation.	None were apparent.
Coherence.	There is no apparent attempt to link the themes in any overall structure, except to say that most of the difficulties described by the themes could be addressed through better group preparation.	The themes were integrated in a diagram. However, it was difficult to make sense of the relationships indicated in the diagram and there was no overview of the model in the text to assist the reader with this. There was no key provided to understand the symbols used and the main themes did not seem to be superordinate to other concepts depicted in the theoretical diagram.	The findings were not systematically grouped into themes or drawn together in a wider framework of themes.
Accomplishing general vs. specific research tasks.	The authors seem to intend a general understanding of the research findings, since they present guidelines for "good group psychotherapy practice" (p.19) in the discussion. However, the findings are based on a limited range of instances (ten participants, recruited from the author's former colleagues).	The authors acknowledge that the methodology does not allow for a general understanding to be reached. They provide a thorough discussion of the findings and the specific impact of the organisational context on the findings.	It is unclear how far the results are intended to be generalised. No limitations in generalising findings are specified. The description of findings is too sparse to give a comprehensive understanding of a specific instance.
Resonating with readers.	It is impossible to judge how accurately the analysis represents the subject matter due to a dearth of quotes and sub-themes. However, the findings seem plausible and are in line with other empirical and theoretical literature in the research area.	The analysis fits with the quotes provided from the service users. The discussion paints a vivid picture of the organisational context that resonated with the author of this review.	The researchers do not describe a systematic methodology or ground their findings in data. Where quotes are presented the conclusions drawn are not clearly justified.

Note. Adapted from Elliot, Fischer and Rennie (1999)

Mason and Adler captured the experiences of men in a prison hospital. Participants felt they lacked control and described a need for external motivators such as recognition by staff. This, albeit extreme, example is consistent with the possibility that the clinical setting and service structure influences group engagement. Mason and Adler (2012) suggested their participants experienced a disconnection between effort and reward due to an unresponsive organisational context. Therefore participants' expectancy motivation (Vroom, 1964) decreased and they searched for external motivators to drive their behaviour.

Two intervention studies investigated how services might build client engagement through improving their experiences outside group sessions. Delsignore et al. (2016) randomised 91 outpatients to CBGT for SAD with or without personalised email contact between sessions. The emails gave personalised feedback and orientating information. The authors found no overall differences between conditions on any measure. However, among a sub-sample of at risk clients (those missing one or more sessions), there was a trend towards lower dropout in the email support condition and generalised anxiety scores were significantly lower at one year follow-up in this condition. These findings could suggest email support was not helpful for engagement, or perhaps the study was underpowered to pick up a small effect size. Furthermore, across both conditions, only around 15% of patients dropped out, compared with a mean of 47% in Wierzbicki & Pekarik's (1993) meta-anaysis of psychotherapy drop out. This may indicate a ceiling effect. Engagement with the tasks of therapy may have been a more useful measure and if differences were found, this might explain the lower anxiety scores of the at-risk clients in the email support condition at follow-up.

Blake, Owens and Keane (1990) present findings from a similar study of rolling groups on an inpatient ward. The authors gave individualised feedback, once a week, to clients who were available. They used an alternating treatments design and found a

statistically significant increase in group attendance during intervention periods. They also found that group attendance during treatment weeks was positively correlated with number of participants given feedback during those weeks. There were a number of shortcomings with this study: The client feedback was given by the study authors who may have sought out more clients on weeks with high attendance and repeated measures t-tests were used to analyse the data but there were different clients on the ward between baseline and intervention periods. However, the idea that feedback and encouragement improves clients' group engagement, fits with the other findings just discussed.

To summarise, the reviewed studies suggest that clients' experiences of being referred to a group and their contact with services between group sessions may impact on engagement. However, the studies' designs preclude any firm conclusions on this matter meaning further research is required.

Building cohesion. Lack of cohesion is considered by many researchers to be: "the most common dynamic component (…) to lead to early client withdrawal from groups" (Marziali, Munroe-Blum & McCleary, 1997, p. 428). This section will explore findings that seem to support a relationship between cohesion and engagement. Alongside this it will consider how cohesion is conceptualised in the literature, both in terms of its dimensions and the level it emerges at (individual or group). Finally one study that did not find a link between cohesion and engagement will be briefly considered and critically evaluated.

The dimensions of cohesion. Cohesion, as conceptualised in the group psychotherapy literature, is generally seen to involve, a sense of bonding and identification with, and interpersonal attraction to the group (Marziali et al., 1997). However, a variety of definitions and measures are used in the literature, including among the studies reviewed. Ogroniczuk, Piper and Joyce (2006a, 2006b) used The Cohesion Questionnaire (Piper, Marache, Lacroix, Richardsen & Jones, 1983), Kivlighan and Paquin (2014) used the engagement subscale of

the GCQ and Hand et al. (1974) used a non-validated "in-house" measure. The research field would benefit from agreeing upon operationalised conceptualisations of cohesion, compatibility, engagement, shared purpose etc. to avoid spurious correlations of overlapping constructs and allow synthesis of their findings. Of the cohesion measures used, the engagement subscale of the GCQ has the best established psychometric properties (MacKenzie, 1983). However, this is not enough to recommend its continued use in this capacity. A conversation in the research field about how best to conceptualise cohesion is needed.

Working towards common goals**.** Cohesion is often theorised to be the mechanism by which other variables impact on engagement. Ogroniczuk et al. (2006a) investigated this empirically. They found that younger clients attended fewer sessions of outpatient group therapy. They followed procedures outlined by Baron & Kenny (1986)
and found statistical evidence consistent with cohesion mediating the effect of age on attendance. Ogrodniczuk, et al. (2006b) in another study found that, in a sample of clients diagnosed with a PD, higher levels of interpersonal distress at baseline predicted higher levels of attendance at supportive group therapy sessions. The authors used Baron & Kenny's (1986) procedures and found cohesion accounted for about two thirds of the effect of interpersonal distress on attendance. Interpersonal distress did not have this relationship with attendance at interpretive therapy groups. The authors pointed out that: "supportive therapy works under the assumption that clients are coming to therapy in some state of crisis" (Ogrodniczuk et al., 2006b, p. 258). Perhaps those participants not in a state of interpersonal distress did not feel they shared in the group's goals for therapy, this precluded them developing a cohesive bond to the group and so they attended fewer sessions.

This interesting finding might suggest that agreement upon the goals of therapy is a necessary condition to build a cohesive group. Indeed some authors conceptualise cohesion

as necessarily involving a sense of working together towards common goals (Marziali et al., 1997). This finding also fits with reports from participants in Bernard and Drob's (1989) study who dropped out of therapy because of a perceived mismatch between their goals for therapy and the operation of the group.

Two of the reviewed studies attempted to manipulate certain variables to improve cohesion and tested its effect on engagement. Murray, Brown and Knox (1964) in a poorly designed study using a small sample and non-blinded observer ratings, manipulated the racial composition of inpatient groups and found this did not have the expected effect on verbal participation of African Americans diagnosed with psychotic disorders. Hand et al. (1974) investigated cohesion in another way. They created structured (S) and unstructured (U) behavioural inpatient groups to treat agoraphobia. In the S groups, clients were encouraged to work on therapy tasks together. In the U groups the therapists made no attempt to encourage interactions between clients. The authors found client-rated cohesion was highest in the S condition. Motivation to apply therapeutic techniques as judged by trial therapists, was higher in the S condition and these groups scored significantly better on measures of phobic avoidance at follow-up. This study has a number of shortcomings. The therapists were not blind to the manipulation or aims of the study and their ratings of engagement were based on qualitative observations. However, phobic avoidance (the main therapeutic task of behavioural therapy), was lower at follow-up in the S groups. This study provides some tentative evidence that cohesion in group therapy can improve engagement with therapeutic tasks. The authors explain this in terms of a greater sense of group purpose, with shared goals and shared tasks, and through observing attractive others, with similar difficulties, modelling coping behaviour (Bandura, 1971).

Cohesion as a group level variable. Kivlighan and Paquin (2014) tested Yalom and Leszcz's (2005) theory that greater group cohesion in a given session is related to group

members enacting more intimate behaviours such as self-disclosure and social risk taking. They argued that cohesion and an engaged group climate are highly related, and so used the engaged dimension of the GCQ as a proxy for cohesion. The authors modelled cohesion as a between-person variable by ranking members on mean cohesion ratings, and as a within-person variable by measuring members' session-by-session deviation on climate perceptions from a within-person constant. The authors found that group members enact more intimate behaviours in sessions that they and others rate as more cohesive (within-person). They found no association between someone's ranking on climate ratings, and the intimate behaviours they enacted (between-person). The authors concluded that a cohesive climate at the group level leads to members enacting more intimate behaviours. However, this is a correlational design so no such causal inference can be confidently made. Also, engagement as measured by the GCQ, measures cohesion, but also self-disclosure and work orientation, so an association between this construct and intimate behaviours is unsurprising.

With these caveats in mind, the authors' findings suggest that the climate of a given session relates with intimate behaviours but a person's ranking on climate ratings does not. Clinically this suggests that keeping track of group climate can be useful and as Flores (2013) notes: "attention (should) be directed not only to the therapeutic growth of the individual (but) the group as a whole" (p.300). This is not a banal point since Stiwne (1994) found that experienced group leaders targeted the majority of their interventions at a subset of individuals and not the group as a whole. Kivlighan and Paquin (2014) recommended that future research should parse between-person from within-person aspects of group climate.

Null finding. Woody and Adessky (2002) found cohesion was unrelated to homework compliance in a sample of 53 clients participating in CBGT for SAD. The study may have been underpowered to detect a true correlation between cohesion and homework compliance. Furthermore, the authors used a non-validated measure of homework compliance that was

solely completed by therapists. Combined client-therapist ratings of compliance have been shown to correlate better with outcomes (Mausbach et al., 2010). Future research might use such combined ratings in larger samples to test if this null-finding is replicated.

Conclusions. The reviewed studies provide evidence that cohesion, as variously defined in the literature, is positively correlated with session attendance, compliance with exposure tasks and the engagement dimension of the GCQ. Mediation analysis suggests cohesion may mediate the impact of age and interpersonal distress on group attendance. However, experimental designs would be needed to confirm this. Hand et al. (1974) demonstrated that cohesion could be manipulated experimentally and that greater cohesion leads to improved engagement with therapeutic tasks and improved outcomes. Finally, Kivlighan and Paquin's (2014) findings demonstrate the importance of perceived cohesion as a group level phenomenon.

Group leadership. Several of the reviewed studies investigated the effect of therapists' behaviour on group engagement. Phipps and Zastowny (1988) found modest but consistent positive correlations between engagement as measured by the GCQ and all the leadership behaviours they measured using the group leader behaviour instrument (GLBI) (Wile, Bron & Pollack, 1970). This might suggest a more "interventionist" leadership approach is positively correlated with engagement. Joyce et al. (1988) measured the behaviours of BCGT leaders using the Therapist Behaviour Categories (TBC) system (Lieberman, Yalom & Miles, 1973). They found therapists in BCGT challenged client perceptions more and provided information more than in long-term GPT, and that avoidance reduced more quickly in these groups. However, we can't infer from this design that leadership behaviour was responsible for the changes in avoidance.

Gruen et al. (1977) examined data from a small sample of 23 outpatients attending GPT. "Group guides", blinded to the study's aims, rated three leaders across 64 sessions. The

authors found that leader anticipation of group themes, control over discussion and depth of interpretations correlated positively with degree of group movement through problems. These findings should be interpreted with caution. The measures were developed "in-house" and have not been validated, and the sample included only three group leaders.

Chapman et al. (2010) examined how leader behaviours relate with engagement in order to test the concurrent validity of their observer-rated Group Psychotherapy Intervention Rating Scale (GPIRS). The GPIRS splits into these factors: group structuring (creating a framework so members understand the group purpose), verbal interactions (modelling and facilitating disclosure and feedback) and creating a therapeutic emotional climate. These factors were developed because previous research has found that they correlate with cohesion, and cohesion with group outcome. Chapman et al. (2010) found that each factor and the overall score were positively correlated with the engaged subscale of the GCQ. They conclude that the strength of leader interventions in these areas impacts on a productive group climate. Again this is a correlational design so causality cannot be confidently inferred. Furthermore the empirical basis for the domains of the GPIRS comes from research on a variety of therapeutic modalities (Burlingame, Fuhriman & Johnson, 2002). Future research should establish the relative importance of these factors in different therapies. However, the GPIRS could be a useful feedback tool to support group therapists in optimising their behaviour to maximise engagement. The other studies reviewed here suggest an active role for leaders may support group engagement.

The Pygmalion hypothesis. A few of the reviewed studies found therapists may interact with future group dropouts differently than remainers. Stiwne (1994) studied a sample of 14 clients diagnosed with borderline personality disorder (BPD) attending outpatient groups over 20 months. The sessions were videoed and random extracts were coded. The authors found that leaders' interventions were significantly more frequently

directed at future remainers than dropouts. This was particularly the case after periods of therapist absence, when the whole group was rated as more withdrawn. Finally, future dropouts became more withdrawn as groups progressed. The authors concluded that clients' trust in therapists was damaged by therapist absences, and clients who became withdrawn in response to this received less input from therapists and eventually dropped out. This could be understood in terms of therapists re-enacting the behaviours of unavailable or inconsistent attachment figures from clients' childhoods (Cassidy, 1999).

There were some shortcomings of Stiwne's (1994) methodology as described. It is unclear whether the extracts were coded by blinded raters, the measures were not validated and the sample size was small. The idea that therapists withdrew from clients who were "acting in", cannot be confirmed given the methodology used. Stiwne's (1994) findings might also be explained by the so-called "Pygmalion hypothesis" (Rosenthal and Jacobson, 1968), namely that therapists perceive particular clients as less likely to benefit from therapy, therefore attend to these clients less and create a self-fulfilling prophecy where these clients drop out. This fits with Oei and Kazmierczak's (1997) findings, who found that therapists rated their cohesion to future dropouts lower than to future remainers. The authors argue that therapists should pay attention to these couuntertransferential feelings and invite reticent group members to participate more in sessions. Connelly et al.'s (1986) findings mirror those described above. They found that therapists rated future dropouts as less significant as group members and expected them to improve less. McCallum et al. (2002) found that future dropouts participated less than remainers, as rated by group therapists, by session one of group therapy. It is plausible that some clients arrive to group therapy less equipped to make good use of the space. However, these findings suggest therapists can spot such clients early in therapy and may sometimes let them drift into the background instead of supporting the most vulnerable members to participate more. Oei and Kazmierczak (1997) suggest that

debriefing or problem-solving with these clients outside group sessions may be helpful, but this has the disadvantage of seeming to favour some clients over others. Future research should attempt to identify the best way of retaining these clients, or supporting them in an informed choice to leave therapy.

Conclusions. The reviewed studies suggest that leaders exerting more control over group discussions is positively correlated with an engaged group climate. Stiwne's (1994) findings suggest that those clients who therapists interact with more are less likely to drop out of therapy. Focussing interventions on the group as a whole may be one way to ensure interventions are experienced by members to be distributed evenly. Chapman et al.'s findings suggest that group structure, a therapeutic emotional climate and modelling and facilitating useful interactions are positively correlated with engagement. The studies reviewed here on leadership do not overlap in client group, treatment modality, leadership measures or outcome measures. Future research should delineate the most important leadership factors for different clients and therapies.

Discussion

The review's findings will now be summarised as they relate to the questions posed earlier and their links with existing theory will be drawn out. Clinical recommendations will be outlined in the answers to question three: "How can therapists and services maximise group engagement?" Finally, the research literature's limitations will be discussed and research recommendations made.

Are Some Therapies More Engaging Than Others?

The review's findings provide no solid evidence that any therapeutic modality should be preferred because of how well it engages clients. There is some evidence that shorter therapies may build engagement, or at least reduce avoidance, more quickly than longer-term

therapies. These findings might be understood in terms of the "temporal frame" held in mind by group members and leaders. Sanna, Parks, Chang and Carter (2005) found that the perceived time available influenced how groups approached tasks. A perception of scarcity of time improved task planning, even as actual time available was held constant. This suggests that creating a sense of urgency may help groups face up to difficult tasks of group therapy more quickly. Future research should investigate this possibility.

Can we Predict Later Engagement from Early Session Variables?

At session one, clients' self-report of affect, their views on other group members, leaders' sense of cohesion to clients and their ratings of clients participation, have all been found to predict later dropout. There is some evidence that leaders' early pessimism about some clients' prospects in therapy may mean that they interact with these clients less and contribute to their withdrawal, the so-called "Pygmalion hypothesis" (Rosenthal and Jacobson, 1968). Other explanations are possible and future research should test competing hypotheses, since the research to date is correlational. One study found that convergence but not congruence with one's group predicted later session attendance, suggesting dynamic variables may predict outcome better than measurements at single time-points.

How can Services and Therapists Maximise Group Engagement? Clinical Recommendations.

4.3.1 Services. The review's findings suggest it is important to attend to clients' experiences of services outside group sessions. It seems client engagement can be improved if clients' sense their goals for therapy are shared by others, including the therapist, and that the group will help them towards those goals. The experience of referral to a group can help in this process. Some clients may lack expectancy-motivation (Vroom, 1964) because of previous experiences of services or if they perceive the service structure as unresponsive to

their needs. In these instances, external motivators may be more important such as encouragement and positive feedback from clinicians. Such feedback may be usefully given between sessions, though further research is needed to test the effectiveness of this.

Clients who drop out of therapy late may experience particularly bad outcomes. Furthermore, absences and departures later in therapy can be particularly damaging for the remaining group. Given this, particular efforts should be made to retain clients in the later stages of therapy, perhaps including contact between sessions. Clients who do drop out should be supported with the emotional impact of this and might benefit from being routinely followed up by services.

Therapists. Therapists might better engender group engagement by setting rough goals for therapy and creating a sense of shared purpose and co-operation between clients on the tasks of therapy. It appears that group leaders can build client engagement through adopting an active role, guiding the content of group discussions. The GPIRS shows promise as an instrument to feed back to leaders on their performance. Research on the GPIRS suggests that creating a therapeutic emotional climate, modelling and encouraging self-disclosure and feedback and providing a containing structure all help build group engagement. However, the active ingredients for different modalities needs to be further researched.

Leaders may be able to spot future threats to engagement from early in group therapy. Clinicians should pay attention to their instincts with regard to "at-risk" clients and aim to retain these clients in therapy, or if necessary facilitate a positive emotional experience of leaving therapy. Leaders should actively encourage quieter group members to participate more. This might be achieved through establishing a group structure that signals a universal responsibility to speak. Bednar et al.'s (1974) risk, responsibility and structure model

suggests this would reduce ambiguity and thus anticipatory anxiety and facilitate greater participation and risk-taking from group members. Alternatively leaders might avoid favouring a subset of clients by consistently attending to the group's needs as a whole. Leaders don't always manage this but a sense of cohesion created within the whole group supports members to enact intimate behaviours.

The timing of leader interventions may be important. For example leaders should particularly aim to limit later group absences. Group leaders should pay attention to group members who are diverging from their group and intervene to support these members before they drop out.

Research implications.

Of the 30 studies reviewed, only eight employed experimental designs. Given this, we cannot confidently make causal inferences from many of the studies' findings. Of the correlational studies, only a small number established temporality (a minimum condition for inferring causality (Hill, 1965) by investigating the association between early process variables on later engagement. Where possible, future research should employ experimental designs or use longitudinal designs that establish temporal precedence and control for likely confounding variables in their analysis, to allow more confident inferences about causality.

The group climate research found substantial heterogeneity between groups in how engagement developed over time, even where no differences were found between conditions. This suggests that the independent variables under investigation did not account for a large amount of variance in engagement. This is unsurprising given the complex nature of group processes. It is likely that a complex interplay of causal relationships that varies under differing conditions is operating. Grounded theory method (GTM) could be used in future research to investigate such complex, dynamic social processes (Uqruhart, 2012).

Some of these complex group processes might be further illuminated through quantitative methods. Multivariate designs should be used to provide information on the relative influence on engagement of the various client, leader and therapy variables already discussed in this review (Johnson, 1998). The dynamics of group processes over time should also be investigated further.

One reviewed study found that those who drop out late in therapy may experience worse outcomes than early dropouts. It's possible that dropping out from an established group is damaging. Despite this, only a few of the older studies elicited the experiences of group dropouts. These studies were generally of poor quality and didn't use any established qualitative methodology to make sense of their findings. Future qualitative research should elicit the views of those who drop out from group therapy.

It will be important for researchers to agree on operationalised conceptualisations of cohesion, compatibility, engagement, shared purpose etc. This would make it more possible to synthesise findings from research and would help avoid spurious correlations where measures and definitions overlap. Factor analysis could determine if concepts should be considered different dimensions of the same construct or related but independent constructs (Fabrigar, Wegener, MacCallum & Strahan, 1999). Nor was there an agreed definition of "drop out" across the reviewed studies. Future research should attempt to unify around a definition of dropout or abandon this dichotomous variable in favour of session attendance or other continuous engagement variables.

Many of the reviewed studies took repeated measures nested within individuals, themselves nested within groups. Multilevel models are required to account for the interdependence of these doubly nested data. Some of the studies reviewed did not do this (for example MacCallum et al., 2002). Future research should take account of this.

The studies reviewed on leadership do not overlap in client groups, treatment modality, leadership measures or outcome measures. They are also limited by their sample sizes. Future research should recruit larger samples of leaders. The GPIRS (Chapman, 2010) has drawn on empirical literature from across modalities to develop a promising leadership measure that could be used to provide consistency in future research on leadership and engagement. Its validity across different therapeutic modalities should be tested.

Conclusions

The review's findings suggest that services can improve group engagement by encouraging discussion and co-operation between clients on the tasks of therapy. Between-session contact with clients at risk of drop out may be helpful. The temporal frame and sense of urgency therapists and clients hold in mind may influence how quickly they face up to difficult tasks of group therapy. Therapists can improve engagement by creating a therapeutic emotional climate, modelling useful behaviours and creating a group structure that reduces anxiety-provoking ambiguity. A therapist focus on the group as a whole may be useful, especially since favouring particular clients may create self-fulfilling prophecies of poor outcomes. Late drop out from group therapy may be damaging and managing the impact of this process on clients can be as important as retaining them in therapy. Qualitative and multivariate methods are required in future research to investigate the complex dynamics of group processes. Longitudinal designs should take account of the differential impact of variables over time. Experimental designs are needed to allow firmer inferences about causality.

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MAJOR RESEARCH PROJECT

Section B: Empirical Paper

BUILDING A GROUNDED THEORY OF ENGAGEMENT IN GROUP PERSON BASED COGNITIVE THERAPY FOR DISTRESSING VOICES

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Abstract

OBJECTIVE: Person Based Cognitive Therapy (PBCT) is a promising group treatment for distressing psychosis. However, fostering engagement in group therapies can be challenging, and no theory of engagement in PBCT groups exists to guide practice or research. This study employed Grounded Theory Method (GTM) to build a theory of engagement in group PBCT.

METHOD: Ten service-users and three therapists were interviewed about their experiences of participating in PBCT groups. GTM following the procedures outlined by Corbin and Strauss (2008) was used to analyse the interview transcripts and build a theory of engagement.

RESULTS: The model that was developed involves a recursive process of investing in change and continually evaluating its usefulness and safety. Barriers were often overcome through individual and group efforts, but sometimes compromised participants' perceived safety to the point of dropout. For others, participating in the group, and incorporating learning into life, led to rewards, some of which were integrated beyond group termination.

CONLUCIONS: Group engagement can be encouraged by establishing universality around voice-hearing early, reducing uncertainty, communicating with clients between sessions and mapping group progress to create a cohering sense of collaboration on the tasks of therapy.

Keywords: Cognitive behavioural therapy, group psychotherapy, qualitative methods, engagement, dropout

Introduction

The National Institute for Clinical Excellence (NICE) recommends that Cognitive Behavioural Therapy for psychosis (CBTp) be offered to people distressed by psychotic symptoms (NICE, 2014). However, access to CBTp remains limited. A recent audit of UK community mental health teams found that only 7% to 20% of eligible service-users had been offered CBTp (Prytys, Garety, Jolley, Onwumere, & Craig, 2011). This shortfall in provision of CBTp is partly attributable to an insufficient number of trained therapists (Berry & Haddock, 2008). One way to improve access is to deliver CBTp in a group format. The evidence for group CBTp's effectiveness is equivocal. Uncontrolled studies have found significant improvements on measures of psychotic symptoms (Chadwick, Sambrooke, Rasch, & Davies, 2000) and perceived voice-control and power (Gledhill, Lobban, & Sellwood, 1998; Wykes, Parr, & Landau, 1999). However, two well controlled trials found no significant effect of group CBTp on: severity of voices, positive symptoms, depression, anxiety or global functioning (Barrowclough et al., 2006; Wykes et al., 2005) compared with treatment as usual (TAU).

Research attention has turned to developing "third wave" acceptance based approaches to improve on these outcomes (Hayes, 2004). One such approach is Person Based Cognitive Therapy (PBCT) (Chadwick, 2006). PBCT integrates CBTp techniques with a mindfulness approach. The mindfulness component supports clients to relate to their psychotic experiences and experiences of self with de-centred awareness. PBCT includes the traditional CBTp focus on beliefs about voices' omnipotence and control but also works across these four domains: (a) the meaning of the voice-hearing experience (b) the relationship between hearer and voice (c) positive and negative views of the self (d) self experienced as dynamic and changing. An analysis of pilot data from nine PBCT groups

found significant improvements in well-being, distress, control of and dependence upon voices following therapy (Dannahy et al., 2011).

PBCT is a promising group treatment for distressing psychotic experiences, but fostering engagement in groups is difficult. One meta-analysis of 125 studies of psychotherapy found a mean dropout rate of 47%, with comparable dropout rates from individual and group therapy (Wierzbicki & Pekarik, 1993). Clients who terminate therapy prematurely report less therapeutic progress and more psychological distress (Pekarik, 1992). Unlike individual therapy, poor group attendance may impact on others, by contributing to an "absence culture" (Gellatly & Luchak, 1998) or leaving other group members feeling insecure, worried, or angry (MacNair & Corazzini, 1994). Given this, research that guides services in improving engagement in group therapies for psychosis, such as PBCT, is vital.

The mental health literature on group engagement to date has primarily focussed on session attendance and avoiding dropout. However, the Group Engagement Measure (MacGowan, 2006), commonly used in the forensic literature, operationalises engagement as involving five dimensions: attendance, contributing, relating, contracting and working. This model may not be generalisable to non-forensic settings. However, a case can be made for the usefulness of a broad conceptualisation of engagement in mental health. Research has shown that homework compliance in group CBT and exposure task compliance in behavioural therapy are associated with reduced symptom severity at follow-up (Neimeyer, Kazantzis, Kassler, Baker & Fletcher, 2008; Schmidt & Woolaway-Bickel, 2000). Furthermore, "engagement" as measured by the Group Climate Questionnaire (GCQ) (MacKenzie, 1981), is moderately to strongly correlated with outcome (McClendon & Burlingame, 2010). "Engagement" as measured by the GCQ captures: "a positive working atmosphere where members self-disclose, confront, care about and support one another" (Thorgeirsdottir, Bjornsson & Arnkelsson, 2015, p.203). Given the association of these various aspects of

engagement with outcomes, the present study will draw on a broad conceptualisation of engagement, and elicit participants' experiences of engaging with a range of therapy tasks and group processes.

Historically, research on group engagement has focused on predicting later group attendance given various baseline characteristics. However, this research has produced inconsistent results and replication failures (Wierzbicki & Pekarik, 1993). Therefore research attention turned to in-group correlates of engagement. Much of this research drew on Yalom and Leszcz's (2005) theorised eleven therapeutic factors of group therapy and investigated relationships between these factors and group engagement. For example Hand, Lamontagne and Marks (1974) found they could engender group cohesion by encouraging co-operation between clients on the tasks of therapy, and cohesion was positively correlated with outcomes and engagement. Randomised trials have, compared engagement between types of group, and tested interventions designed to improve engagement. Bakali et al. (2013) found that shorter groups may benefit from accelerated engagement. Two trials found engagement can be improved through between-session contact with services (Blake, Owens & Keane, 1990; Delsignore et al., 2016). However, these trials all found large variation in engagement within and between groups that was not accounted for by the variables theorised to affect engagement. This is unsurprising given the complex nature of group processes. It is likely that a complex interplay of causal relationships that vary under differing conditions is operating (Paquin & Kivlighan, 2016). These complexities can be usefully investigated through qualitative designs.

Grounded theory method (GTM) is a qualitative methodology well suited to investigating complex, dynamic social processes (Uqruhart, 2012) such as group engagement. GTM can be used to generate theory in poorly understood areas such as engagement in group PBCT. One previous study successfully employed GTM to provide a rich account of

participants' experiences in group PBCT (Goodliffe, Hayward, Brown, Turton & Dannahy, 2010). However, this study did not focus on engagement.

A systematic literature search found no GTM research to date on engagement in group psychotherapy for mental health problems and no extant model of engagement in group therapy for mental health problems. Given this, the aim of the present study was to build a grounded theory of engagement in group PBCT, drawing on the experiences of therapists and clients who have experience of PBCT groups.

There is some evidence that the process of dropping out of established psychotherapy groups may be damaging (Stiwne, 1994). Eliciting the views of clients who have experienced group dropout could guide practice in retaining such clients or supporting them with the impact of dropout. Despite its potential clinical utility, a systematic literature search revealed only a few studies on engagement that elicited the experiences of those who had dropped out of group therapy. (Bernard & Drob, 1989; Stone et al. 1980; Yalom, 1966). The only study that employed an established qualitative methodology was conducted in a forensic setting (Mason & Adler, 2012). Given this, the present study specifically aimed to elicit the experiences of those who had dropped out of PBCT groups in building a theory of engagement.

Method

Context

All participants were involved with one of six 12-session PBCT groups for distressing psychosis (Chadwick, 2006) in an NHS trust in the South of England. The group intervention was embedded in a stepped-care model. All patients referred to the clinic received four sessions of coping strategy enhancement prior to group therapy (CSE) (Tarrier, 1990). CSE explores service-users' existing coping strategies for dealing with distressing voices and supports them to apply these more systematically.

Participants

Inclusion criteria. Eligible service-user participants were experiencing auditory hallucinations at the time of intervention, as measured by scoring four or above on item P3 of the Positive and Negative Syndrome Scale (PANSS) (Kay, Flszbein & Opfer, 1999). The hallucinations must also have been causing significant distress, as indicated by scoring 3 or above on one of the distress items of the Psychotic Symptoms Rating Scale (PSYRATS) (Haddock, McCarron, Tarrier & Faragher, 1999). The voices clinic adopts a transdiagnostic approach and service-users were not excluded on the basis of diagnosis. Group therapists were eligible if they had facilitated at least one PBCT group within two years prior to participation.

Participant Characteristics. 13 people participated in the study, ten service-users and three group therapists. This is comparable to participant numbers in published grounded theory studies of CBTp (for example McGowan & Lavender, 2005). The participants were aged between 24 and 68 (patient mean = 41, therapist mean=41). Nine service-user participants were hearing voices and one was distressed by hearing music. Characteristics of the voices heard by the service-user participants are reported in Table 1, along with demographic information. All service-users were receiving standard psychiatric care, including medication. Three dropped out of a PBCT group and seven completed, attending at least nine sessions. All therapists were clinical psychologists who facilitated separate PBCT groups. See Table 1 for a summary of participant characteristics. Information on gender has been removed from the main text since this might make some participants identifiable. See Appendix V for an unabridged table of participant characteristics.

Table 1

Participant Characteristics

Pseudonym	Involvement	Age	Ethnicity	Months since last group contact	Diagnosis	Voice content	Years of voice hearing
Roger	Therapist	50	White British	0	NA	NA	NA
Paul	Patient	41	White British	0	EUPD	Co. Cr. Cm.	20
Dexter	Patient	36	Mixed Race	0	EUPD	Co. Cr.	22
Debbie	Patient	47	White British	0	EUPD	Co. Cr.	15
Ryan	Patient	24	White British	0	Schizoaffective Disorder	Co. Cr. Cm.	11
James	Patient	29	White British	0	Schizoaffective Disorder	None.	12
Billiana	Patient	39	White Other	0	Schizophrenia	Co.	10
Mozart	Patient	68	White British	0	Schizophrenia	Co. Cr.	55
Tracy	Patient	51	White British	3	EUPD	Co. Cr.	30
Jim	Therapist	42	White British	20	NA	NA	NA
Louise	Therapist	30	White British	20	NA	NA	NA
Sam	Patient	36	White British	18	EUPD	Co. Cr. Cm.	10
Taylor	Patient	41	White British	8	DID	Co. Cr. Cm.	40

Note. EUPD= Emotionally Unstable Personality Disorder. DID=Dissociative Identity Disorder. Co = comments on participant's activities. Cr = criticises. Cm = gives commands. NA= Not applicable.

Design.

GTM, following the procedures outline by Corbin and Strauss (2008) was used to generate and analyse data. A critical-realist epistemological stance was adopted in planning the research. A critical-realist stance views the process of data generation as one of co-creating a narrative of experience that corresponds to an objective reality to an unknowable extent.

A semi-structured interview schedule (Appendix I) was developed in consultation with the research supervisors and a trust service user advisory group with experience of the

voices clinic. The interview topics included: worries and hopes before starting the group, facilitators and barriers to engagement, and thoughts about carrying learning forward after group completion. Interviews were guided by the use of open questions and prompts. However, a person-centred interview style was adopted to elicit the personal concerns of participants (Wimpenny & Gass, 2000).

Ethical considerations

Ethical approval was obtained from the London-Fulham Research Ethics Committee (REC) (Appendices C & D). Research governance approval was obtained from an NHS trust research and development department (Appendix E). The British Psychological Society Code of Conduct (BPS, 2009) was followed. Capacity to consent was assessed by the author prior to the interviews and participants' understanding of the pros and cons of participation was checked afterwards. The author, who conducted the interviews and analysis, was not involved with service-user care in the clinic, nor had he any authority over therapists. The author discussed the slight risk that the interviews could cause distress with participants beforehand, offered breaks during the interview and adopted a warm, person-centred interview style to minimise the risk of causing distress.

Procedure

Participant recruitment. All service-users from two PBCT groups (N=16) were approached by clinic research assistants during routine appointments and were given participant information sheets (Appendix F). Those who indicated interest in the study were contacted by the author. Informed consent was sought immediately prior to the interviews. See Appendix H for the consent forms used.

Later two other service-users who had previously dropped out of a group, were contacted by clinic staff. These service-users were theoretically sampled to broaden the

explanatory power of the emergent theory (Corbin & Strauss, 2008). Both service-users had indicated they were happy to be contacted again by the clinic for research purposes, and agreed to participate. The author contacted potential therapist participants directly. The author answered questions about the study over the phone and arranged research interviews with interested therapists.

Data Generation. Interviews took place between zero and 18 months since last group attendance. Two service-users were interviewed twice, six months apart, in line with GTM theoretical sampling (Corbin and Strauss, 2008). Interviews lasted between 15 and 71 minutes (mean= 34 minutes). In keeping with the GTM principle of theoretical sampling, the interview schedule was revised (see Appendix K) to explore emergent hypotheses after early data generation and analysis (Corbin and Strauss, 2008). This process was done in consultation with service-user advisors who gave their views on the early analysis and suggested avenues to explore in the revised interview schedule. Appendix J contains notes from a consultation meeting with the service-user advisors.

Data Analysis.

The data were analysed in keeping with methods outlined in Corbin and Strauss (2008). The software package NVivo 10 was used for managing and analysing the data. In keeping with GTM principles, data analysis ran concurrently alongside data generation. After every one to three interviews, transcription and coding took place. The first four interviews were open coded, line by line, to sensitise the author to the range of potential meanings in the data and develop concepts. Concepts were grouped and higher order categories began to emerge. The categories' properties and dimensions of interest were then developed. Axial coding was used to elucidate relationships between categories and sub-categories along their properties and dimensions. As the core category of interest began to emerge, selective coding was undertaken to densify categories and specify their relationships to the core category.

'Constant comparison' (Glaser & Strauss, 1967) was used throughout the analysis to compare data instances, codes and categories with one another. Memo writing and diagramming were used to develop concepts and relationships between concepts (Appendices O & P).

Quality Assurance Methods

Elliott, Fischer and Rennie's (1999) guidelines for qualitative research were followed to ensure quality control. "Owning one's perspective" was scaffolded by keeping a reflective diary throughout data generation and analysis (see Appendix L) and by theoretical memoing in relation to personal perspectives on, and emotional reactions to the data generated (see Appendix P). The author's epistemological and theoretical perspectives are discussed in the next section. "Grounding in examples" was achieved by producing Appendix M, which grounds all the open codes with example quotes, and the coded transcript in Appendix N. The "credibility" of the codes and category development was audited by the study supervisor. Appendix O shows how the model was iterated over time. Finally, Appendices R and S show how the codes changed over time as they were abstracted further. This also gives an indication of how well supported these codes were, by listing their number of instances in the data and their spread across interview sources.

Theoretical orientations and personal anticipations. At the time of data collection I had experience of working clinically in the voices clinic, delivering CSE. I undertook a scoping literature search before forming the project proposal. These experiences and learning meant I anticipated a powerful role for group common factors, especially universality, in participants' experiences (Yalom & Leszcz, 2005) The systematic literature review reported in Section A was conducted after data analysis was complete.

Results

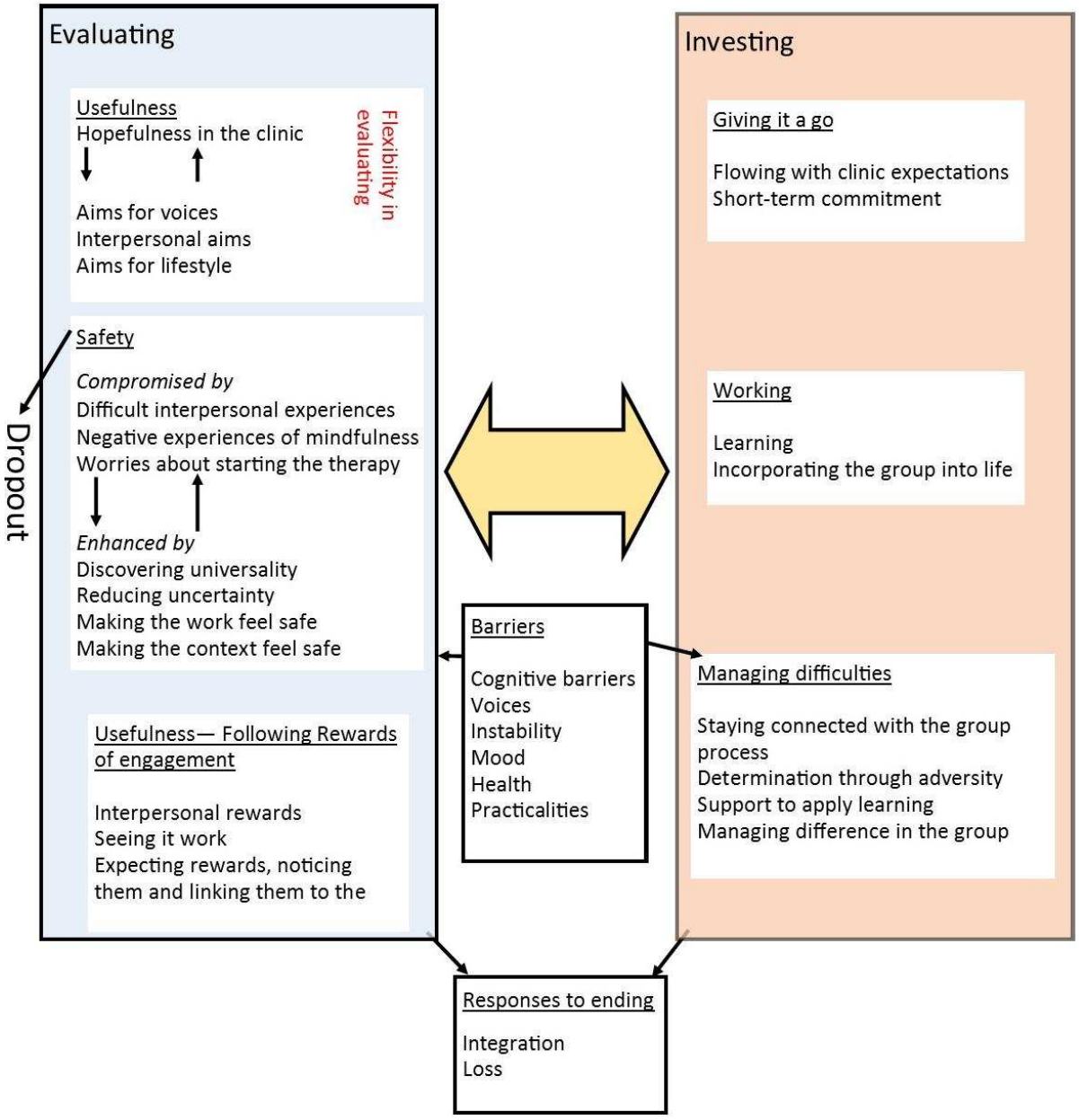

Figure 1. Investing in changes that seem safe, manageable and useful – a model of engaging in group PBCT.

Overview of the model

Figure 1 is a model of the process of engaging in PBCT group therapy. Categories and sub-categories are presented in Table 2 and are highlighted in the text in bold. The model depicts a recursive process of **investing** in the group and **evaluating** it in terms of its **usefulness** and **safety**. If its **safety** in particular is **evaluated** to be lacking at any stage, this

may lead to participant **dropout**. That said, the initial period of group engagement is often characterised by **flexibility in evaluation** and an **initial short-term commitment** i.e. **giving it a go.**

Investing and **evaluating** dovetail over time and do not follow a strict sequence. However, a few rules of thumb seem to apply. Firstly, **safety** is more important to participants in earlier stages. Secondly, participants initially **evaluate** the **usefulness** of the group on relevant past experiences and their **hopefulness in the clinic** approach. Later they use direct experiences of **seeing it work** for themselves and/or other group members. **Working** in the group, by **learning** and **incorporating the group into life**, can lead to various **rewards of engagement**, including **interpersonal rewards** and **seeing it work**. If group participants **expect rewards, notice them and link them to the group**, this particularly motivates ongoing **investment**.

Participants face various **barriers** to fruitful group engagement. **Managing these difficulties** can be achieved in a number of ways. However, these **barriers** can significantly impair fruitful engagement and impact negatively on **evaluations** of the group, particularly its **safety,** and thereby precipitate dropout. Participants' **responses to (group) ending** are various. Participants **integrate** some benefits into their lives, while others are **lost**. The categories contributing to the model will now be considered in more detail. Quotes will be used to exemplify the categories and sub-categories.

Core category.

The core category that emerged from the analysis was **"investing in changes that seem safe, manageable and useful".** This section will briefly summarise how the other categories relate to the core category and how it accounts for large variations in engagement. Some participants dropped out early (stopped investing) because they felt the group wasn't safe for

them. Other participants kept coming back and working hard because they witnessed the group's usefulness. "Barriers" affect how manageable changes are and require extra investment or they will compromise safety/usefulness. Responses to ending can be seen as further investment in change and again this is influenced by personal barriers interacting with evaluations of safety.

Table 2.

Categories and Sub-Categories of a Model of Engagement in Group PBCT.

Categories	Sub-categories
A. Giving it a go	1. Giving it a go
B. Safety	2. Worries about starting the therapy
	3. Making the context feel safe
	4. Reducing uncertainty
	5. Making the work feel safe
	6. Relaxed informal atmosphere
	7. Negative experiences of mindfulness
	8. Difficult interpersonal experiences
	9. Discovering universality
C. Working	10. Learning
	11. Incorporating the therapy into life
D. Usefulness	12. Aims for voices
	13. Interpersonal aims
	14. Hopes for life
	15. Hopefulness in the clinic
	16. Flexibility of evaluation
	17. Useful learning
	18. Interpersonal rewards
	19. Expecting rewards, noticing them and linking them to the therapy
E. Barriers	20. Barriers
F. Managing difficulties and renewing commitment	21. Managing difference in the group
	22. Interpersonal support to apply learning

	23. Determination through adversity
	24. Staying connected with the group process
G. Responses to ending	25. Integration
	26. Loss

Category A. Giving it a go

Participants described flowing with clinic expectations in the first instance. For example*, "…if they've gone to all this effort then you would go rather than not go" (Mozart*, service-user). This code captures the external nature of some participants' initial motivations. This was often a short-term commitment. For example*, "Part of me was not quite s*ure about *this but I'll go to a couple and see what it's like" (Debbie*, service-user). This initial investment allowed participants to gather more information with which to evaluate the usefulness and safety of the group. Many participants acknowledged suspending judgement until they had this information (a code under the sub-category 'flexibility in evaluating'). For example, *"I think just letting the experience just talking for itself rather than having too many preconceptions about how it's going to be was important for me"* (James, service-user).

Category B. Safety

Participants continuously evaluated how safe they felt in engaging with the therapy and this linked with their willingness to make ongoing investments. For example, *"I also* really struggled wi*th the mindfulness (…) I just completely dissociated (…) which was really frightening (…) I was asked if I wanted to continue (…) But that didn't really seem to me very worth doing" (Taylor*, service-user). Various factors compromised participants' sense of safety. Participants arrived with **worries about starting therapy.** Among other things, these worries were sometimes based on past experiences of services and sometimes on stigmatised attitudes about voice hearers, including themselves. Most reservations centred on

interpersonal concerns, such as worrying about being judged, seeming crazy, performance anxiety, privacy concerns and encountering disruptive others. For example, *"(...) if other people would just be too ill or would disrupt the group somehow (...) an*d there was the *concern that they would all be really lovely but (...) I would look like the wacky one of the group." (Sam*, service-user). Participants also acknowledged anxiety about introspecting in therapy. For example, *"I think one of the beliefs that (...) practitioners and* service-users have within services is that focussing on voices can increase them and therefore increase *their distress." (Jim*, therapist).

It was important in the early stages of therapy to **make the context feel safe.** Participants valued feeling held by caring clinic staff and by group boundaries being codified in a written agreement. Therapists consciously deployed consistent strategies to create a containing atmosphere. For example, *"So what else am* I doing to help people engage? Very, *very basic fundamental things like using people's names, looking at them in the eyes, acknowledging them when they speak and thanking them for sharing." (Jim*, therapist). Participants were also reassured by the small group size and by being given explicit permission to leave the room if feeling anxious.

Participants varied in the specificity of their concerns before therapy and some worried about encountering a new setting per se. Given this, strategies aimed at **reducing uncertainty** helped to build engagement. Specifically, participants welcomed the familiar NHS location, the consistent structure of sessions and the opportunity to 'size things up before jumping in'. For example, *"I sat there quite quietly, not talking r*eally and just trying to size it, *up what was going to happen." (Paul*, service-user). Others felt there wasn't enough time to size things up and that led one participant to drop out. For example:

*"It was kind of straight in to the relaxation thing (…) May*be the first time you just, I *don't know, have a cup of tea and maybe talk about what's going to happen in the future (…) I just couldn't do it." (Tracy*, service-user).

The contrasting responses quoted above might suggest a differing sensitivity to threat among participants. For example, *"I think people were a bit shy and I'm not shy so I was just talking loads." (James*, service-user). This contrasts with Dexter's experience: "Because with my borderline I have to always look at the door. I have to always feel safe. I know that *I've got trust issues."* This difference among group members was useful since extrovert group members tended to lead the way. This **made the work feel safe,** as did the therapists setting manageable expectations but working towards a universal responsibility to speak. This responsibility served several functions including reducing uncertainty, allaying fears of being judged by silent group members and building group members' confidence through active participation.

Participants valued some of the boundaries set by the clinic as mentioned above. This seemed to protect against worries about other group members. Conversely participants valued the sometimes informal nature of the clinic's role. This **relaxed informal atmosphere** seemed to protect against worries about the clinic itself and the group content. Participants repeatedly praised a seeming lack of hierarchy, hospitality and informal conversation, a lack of rigid rules, especially around leaving the room, and the role of humour. For example, *"and even if I don't make it very well in the week I know that when I go to the group I've got that supportive atmosphere and that it doesn't feel like a hierarchy from Roger to us." (Debbie*, service-user).

Participants moved from evaluating their safety based on past experiences and pre-existing attitudes, to direct experience of the group. All three participants who dropped out of

a group cited feeling unsafe as their reason for doing so. This generally, but not exclusively, resulted from **negative experiences of mindfulness**, including practices triggering a sense of threat, flashbacks and voices, and feeling disconnected from the group while others meditated "happily". Some of the participants' who dropped out, reported that their sense of threat was intense and enduring: For example, *"I didn't sleep because I was worried about going (…) my anxiety was getting really bad and I was having flashbacks of all the things I didn't like from the week before." (Tracy,* service-user). Others felt the sense of threat was intractable: For example, *"I just imagined that would keep happening (…) I think it's just not for me really" (Sam,* service-user). This can be contrasted with mild anxiety that resolves during a session. For example, *"I felt a bit self-conscious about doing it (…) but by the end of it I was able to sit and relax properly" (Paul,* service-user). Or problems that felt solvable in collaboration with the clinic over time (see category F). One of the participants who dropped out, reported feeling ambivalent about doing so, and for that reason would have valued ongoing contact with the clinic as a means to reconnect. For example, *"Maybe I should have told her to call me back because maybe I would have gone back." (Tracy,* service-user). This participant reconnected with the clinic as a result of participation in this research.

Participants also reported a variety of **difficult interpersonal experiences in the group.** Some participants described a general tendency towards interpersonal anxiety, while others specified that the level of disclosure expected was too exposing. Some group members were distressed by the unusual views of another group member who they perceived as different from the group. Other participants felt different and misunderstood themselves:

"For me it's different because I'm always the odd one out. I feel like I'm the only mixed race one or I'm the only one that looks different from everyone else. I always feel like I'm the only one that speaks out, so it's quite hard sometimes when you've got to fit in to different groups." (Dexter, service-user).

The anxiety of feeling different was ameliorated by **discovering universality**. This often seemed to happen quickly. It was enhanced by the universal sense of purpose of the NHS location and by bringing voices into the open early. Participants felt this allowed them to then invest in the group by taking a risk and being open. For example, *"you feel part of the group and because they've all got the same thing, it helps* you to talk. Get all your thoughts *out that you've bottled up."(Paul*, service-user).

Category C. Working

Participants described **learning** from facilitators and one another, particularly how to deal with voices without fearing them and how to understand them better. For example, *"they're helping you to understand that the voices can't harm you and you can resist what they're saying" (Paul*, service-user). Participants described a number of challenges in **incorporating the therapy into life**. This involved making time for the group, developing strategies to prompt home practice and refining techniques through trial and error. For example,*"because I do it, I try it and if it don't work, well I'll move to something else."* (Ryan, service-user). Participants noted that different physical environments (for example, quiet vs. noisy) and different emotional states (relaxed vs. agitated) were more or less conducive to applying the techniques successfully. For example:

"*It just makes me feel like I can't sit there concentrating on it properly because I feel* too agitated so I- *but when I'm a little bit calmer, when I've calmed down a bit I'm able to sit* down and listen to it properly." (Paul, service-user)

Despite this, some participants planned mindfulness practices proactively, while others reacted when they felt it necessary. For example, *"at night is a time when I'm panicking because that's the worst time and I'm flooding the room with lights and-* so usually *it's a panic stricken, '*oh my god I must do the mindfulness now*'." (Debbie*, service-user)

Category D. Usefulness

Participants arrived with a variety of **aims for the voices** including understanding them better, controlling them and getting rid of them completely. Participants also discussed **interpersonal aims**, including catharsis and sharing experiences with like-minded others. This seemed to be particularly driven by a lack of opportunity to discuss voices in routine services and the effects of stigma in silencing help-seeking from family and friends. For example, "*…just to be with other people that were experiencing the same thing, because it's* not something you can just talk to anyone about really, is it?" (Tracy, service-user). Participants also talked about their **hopes for their lives.** Participants spoke of voices driving self-harm, limiting one's horizons and affecting one's family. When discussing the impact of voices in this way, participants repeatedly talked about a need to change. This felt need to change resulted in a determination to maximise engagement as discussed later (see category F) and can be contrasted with **giving it a go**. For example, *"I just throw myself in (because…)* I have to do *this. I have to. Because if I don't do this I'm going to be like this the rest of my* life and I want to do things with my life." (Ryan, service-user)

Before beginning therapy, participants seemed to evaluate the potential usefulness of the group based on their aims (discussed above) and their **hopefulness in the clinic**. **Hopefulness in the clinic** was determined by participants' prior experiences of services, their hopefulness in a group approach and their ability to accommodate a psychological model of voice hearing. For example, *"I think people might have this idea that psychological therapy (…) it's just peripheral to the main treatment, which is medication and monitoring. So (…) why would I do it?" (Jim*, therapist). Positive experiences of level one of the clinic (four sessions of individual therapy before starting the group) seemed to engender hopefulness, but expectations of a group approach often had a countervailing effect. For example, *"From doing my one on one (…) because she was so good working with me, I thought (…) "oh the*

group's going to be really shit because it's not one on one." (Dexter, service-user). Some participants showed **flexibility in evaluating** the usefulness of the group by suspending judgement at first (as discussed in category A) and adjusting their expectations over time. For example, *"at first I thought it would maybe get rid of it (the voices) altogether (…) but I've learnt that they can't get rid of it altogether but they help you to understand it." (Paul*, service-user).

As participants began to engage with the therapy they were able to evaluate its usefulness based on the rewards of engagement. This included **useful learning,** such as searching for evidence to question voices, gaining autonomy over voices and mindfulness aiding relaxation. For example: "sometimes when the voices tell me something I question *them now. Because I think, "yea Roger's right, he says "you need to have evidence""* (Dexter, service-user). Many participants also reaped **interpersonal rewards** from engaging in the therapy, including, universality/ shared suffering, feeling understood by others, finding one's contributions were respected, exchanging in compassionate interactions, catharsis, a cohesive attachment to the group and the self-esteem gained by inspiring others. For example, *"you want to communicate your ideas and hopefully be some kind of role model really"* (James, service-user).

The extent to which these rewards motivated further investment in the therapy was determined by how much participants **expected, noticed and linked rewards to the therapy**. For example, *"I: (What) made you want to keep attending the group? (…)*

J: (…) Just knowing that the mindfulness was helping me and making a difference." (James, service-user).

Sometimes participants noticed progress in the moment, including pride in group participation. For example, *"…the roleplay moments where everyone went, '<gasp>' and didn't*

want to actually meet Roger's eye (…) and actually I found myself offering*." (*Debbie, service-user). At other times the clinic purposefully drew participants' attention to their progress. One way the clinic managed this was by mapping the group journey. For example, *"They always have it on the wall. What we did the previous week. (…) So we all know, (…) "the voices are not true because we did go for a coffee or someone went swimming". (Dexter*, service-user). This quote demonstrates that the therapeutic task of finding evidence to question voices, dovetails with noticing progress. Many participants found this particularly motivating. For some, the rewards of engagement were pronounced, while others drew pride simply from attending the group, and drew hope from participating in a group journey and seeing others cope.

Category E. Barriers

Problems arising from a group approach per se or the therapy content, for example mindfulness, have been grouped under "evaluating", rather than barriers to engagement. The barriers grouped here are personal barriers, or external barriers not intrinsic to the therapeutic approach. For example participants faced cognitive barriers, unstable home lives, physical health problems, mood problems, interfering voices, problems with the clinic location, and technical problems with the mindfulness recordings. For example, *"either* [I] *didn't* understand the question Roger was doing or I just- *sorry I have bad memory as well, it's not helping." (Mozart*, service-user). These obstacles ranged from momentary and irritating, to enduring and debilitating. They affected the safety and usefulness of the therapy. For example:

"I think to be honest he has a fairly bad drug problem. I think for him just organising himself to get to the group was quite difficult: finances, getting enough money together to get

a bus and I think he just had a *fairly chaotic lifestyle so that made it hard." (Louise*, therapist).

Managing difficulties and renewing commitment.

The strategies deployed to maintain the usefulness of the therapy in the face of these barriers and those arising from a group approach and the group content are described here. Some difficulties were predictable and had reliable solutions while others were idiosyncratic, arose unexpectedly and required tailored solutions. Problems were solved by individuals, facilitators, or through collaboration between people.

Participants **managed difference in the group** through: regulating their own behaviour to fit in, pairing with a like-minded other and showing compassion for people who were group outliers. Participants felt that the clinic modelled this compassionate approach but also that their underlying commonalities drove mutual respect. For example:

"There's one of the ladies is very religious and (…) she can sometimes say quite strange things (…) I think we've learnt through the facilitator to care for her and respect she (…) may be a bit different but she's equal in her rights to have a voice." (James, service-user).

Sometimes the clinic took on the job of regulating contributions from people who were outliers in the group, to the extent that one group member was asked to leave. *"And we felt that actually her presence in the group was too disruptive in terms of the flow (…) because she would just sit there stone faced (…) not engaging at all. (…) So we aske*d her to *leave." (Jim*, therapist).

Participants availed of **interpersonal support to apply learning** from friends and family, other services and other group members. They worried about this support ending when the group ended, as acknowledged by Roger: *"Ideally we would have a meeting with*

everyone's care-coordinator at the end of therapy *(…)* to ensure that learning is placed in *multiple hands"* (Roger, therapist). Participants seemed better able to tolerate difficult aspects of the group when others shared those difficulties. For example, *"there were a couple of people who didn't really like mindfulness (…) So it felt much easier for me to say, '*yea I *didn't really get on with it'"(Dexter*, service-user). This contrasts with an experience of Tracy's, which was part of the reason she dropped out: *"I just felt really awkward because* everyone *else was doing what they were supposed to be doing and I wasn't." (Tracy*, service-user).

Where participants felt they had much to gain from therapy, they showed real **determination through adversity**. For example, *"I managed to go but it took me about four* hours to get out of the house and go*"* (Dexter, service-user). This quote captures Dexter's determination to apply learning at home, but many participants also spoke of their determination to maximise group attendance and their disappointment at missing a session. Participants found it harder to go back after missing a session but this was helped by **staying connected with the group process**. This was achieved in a number of ways, for example by the clinic phoning group members between sessions. This meant participants felt held in mind and cared for but it also assuaged guilt about missing a session and allowed the clinic to support group members with individual problems. For example, *"I made it back the next* week, because they ring you *(…) So I told them what had happened (…) and now they manage her differently" (Dexter*, service-user). Some participants also valued being called after they dropped out. This allowed them to leave on good terms and consider reconnecting with the clinic in future.

Category G. Responses to ending.

All but one service-user participant described feeling worried about therapy coming to an end. Participants were worried about the **loss** of an outlet to discuss voices, a witness to their progress and a sense of group belonging. Many participants felt they might 'go downhill' after the group ended. For example, *"What about all I've done, going out and* everything, making big steps. What am I going t*o do? If it stops (…) what if I go downhill? And what if I just go downhill? And I can't go downhill." (Rya*n, service-user). However, three of the four participants interviewed after finishing or dropping out of a group, described integrating aspects of the therapy into their lives in various ways.

Participants described internalising positive aspects of the group experience long after the group had finished, including universality and the hopefulness of seeing others cope:

*"I suppose I've still held o*n to the fact that there are people who suffer with voices *but they can really get on with their lives and really deal with them. (…) So yea, that's been really positive." (Sam*, service-user).

Interestingly Sam dropped out of the group early and didn't report a particularly positive experience overall. The above quotes contrast with the perspective of two of the group therapists who felt these "common factor" effects would be short-lived. For example:

*"The fact that you have the same experience as me is co*mforting in the moment but *that's all well and good. When I go home I'm still hearing voices, I'm not going to think, '*oh *Ciaran also hears voices, isn't that really comforting'." (Jim*, therapist).

Participants also **integrated** new learning about voices and mindfulness techniques into their lives to varying extents. Some participants continued to use the mindfulness recording and incorporated this into their routine, while others drew upon mindfulness in flexible and idiosyncratic ways. For example:

"It's not just one exercise but that there are lots of different ways you can practice mindfulness. It doesn't have to be something you have to listen to on an mp3 player." (Debbie, service-user, T2).

Participants also varied in their aims in applying mindfulness, with some using it to endure difficult new situations and others using it to enhance pre-existing coping strategies, including avoiding activity. For example,

"In the afternoon it always seems worse. (…) And then I think, "I'm going to go to bed". So then I lie in bed and put the mindfulness thing on and I can feel it calm me down because it's quite relaxing." (Paul, service-user, T2).

Most participants felt that ongoing social support was necessary to apply the learning from therapy. However, some thought quite flexibly about who could provide this support (including community mindfulness groups) while others saw this as a dichotomy between supportive mental health services or self-sufficiency. For example, "What if they *ain't got* anything else for me? And then I have to do it myself again?" (Ryan, service-user). As discussed earlier this may be partly driven by stigma. "It's really tough because it's not like you can advertise on Facebook. *'I'm starting a group'. It's all very secretive, it's all behind* closed doors" (Debbie, service-user). Most participants had never heard of the hearing voices network and only one considered that she could recruit ongoing support with mindfulness practices outside a mental health setting.

Discussion

This study is the first attempt to build a theory of engagement in a group therapy for mental health problems outside a forensic setting, using a rigorous qualitative methodology. The findings provide a model for understanding engagement processes in group PBCT. This study also makes a unique contribution by incorporating the views of people who dropped out

from group therapy into the analysis. The core category that emerged from the analysis was: "investing in changes that seem safe, manageable and useful". The study's findings will now be discussed in relation to established theory, clinical and research recommendations will be drawn out, and the study's limitations will be discussed.

Links with extant literature.

The model of engagement depicts a recursive process of investing in change and evaluating its usefulness and safety. This can be understood in terms of expectancy-motivation (Vroom, 1964). Participants' expectations about achieving their goals through therapy appeared to initially be informed by past experiences, and later by direct experience of the group, and these expectations seemed to drive their motivation. The sub-category "expecting rewards, noticing them and linking them to the therapy" captures this process.

Participants' hopefulness in the clinic before therapy was also influenced by their perception of the compatibility between the clinic approach and their personal aims. This fits with studies that suggest agreement on the goals and tasks of therapy is a necessary condition for group cohesion (Bernard & Drob, 1989; Marziali et al., 1997). Cohesion (Yalom & Leszcz, 2005) emerged as an "interpersonal reward" in the present study. Participants in this study may have gained a cohering sense of collaborating on shared tasks through the "group journey" being mapped on the wall week by week. Some participants' acknowledged their hopes only converged with the group aims over time. Previous research by Paquin, Kivlighan & Drogosz (2013) found that convergence but not congruence with one's group was related with session attendance. The findings discussed above may support the importance of convergence in building engagement.

Participants faced several threats to their perceived safety in the groups. Several reported worrying that they would be seen as "crazy" or that others would be "too ill". This

could be seen as internalised stigma about mental health problems, which has been found to interfere with help-seeking (Clement et al., 2015). Indeed many participants found it cathartic to finally discuss voices in depth, since they felt unable to do so with others in their lives due to perceived stigma.

Many participants acknowledged that they were reluctant to speak in their group at first due to some of the interpersonal concerns already discussed. Most people overcame this by recognising that others shared similar experiences of voice hearing. Participants cited perceived universality (Yalom & Leszcz, 2005) as a facilitator of, and an enduring reward of engagement even long after groups had ended. Some participants felt they gained by learning from similar others in the group. This could be understood in terms of social learning theory (Bandura, 1961).

Other participants reported that they were able to speak for the first time in the group because their group therapist elicited contributions from everyone at particular times in each session. They perceived that there was a universal responsibility to speak and this norm helped them to take a risk and self-disclose. This fits with Bednar, Melnick & Kaul's (1974) risk, responsibility and structure model. This model posits that group structure reduces ambiguity, and thus anticipatory anxiety, and facilitates greater participation and risk-taking from members. "Reducing uncertainty" emerged as a sub-category in the present study. Many participants also noted that the familiar session structure and written group agreement reduced their uncertainty and facilitated their participation. The group therapist systematically eliciting contributions from everyone may be useful in another way. Research has shown that group leaders can sometimes let quieter group members withdraw from discussions and these participants are at particular risk of dropping out (Stwine, 1994). This may be due to a self-fulfilling prophecy: group leaders have less therapeutic optimism about particular clients, who then confirm leaders' expectations by dropping out, the so-called

"Pygmalion hypothesis" (Rosenthal & Jacobson, 1968). Systematically eliciting contributions from all group members may guard against this.

Some participants reported finding it particularly difficult to go back after missing a session. These participants found that phone calls made by the clinic between sessions helped them return to the group. Beyond this, seven from ten patient participants made positive mention of the clinic phone calls. This fits with findings that between session praise and encouragement improves attendance at group therapy (Blake, Owens & Kane, 1990) and that this may have particular benefits for service-users who have missed some sessions (Delsignore, et al., 2016).

Clinical recommendations

As just discussed, participants valued structures that reduced ambiguity, and thus ameliorated their anxiety. Given this, a leaflet was produced and posted to clients of the clinic in the present study, prior to their beginning group therapy (see Appendix W). This was aimed at reducing uncertainty and instilling a sense of universality, and hopefulness in the clinic approach – two other factors that were found to facilitate early engagement in the present study. The findings presented here suggest such an intervention may facilitate engagement, though this should be tested empirically.

Two participants attributed their dropping out of therapy to mindfulness. Sharing difficulties with mindfulness practices seemed to help others stay in therapy. However, some acknowledged that they didn't feel able to share their concerns. While it is not clear from the data why these participants felt unable to speak, the existing literature provides a range of plausible explanations. Bernard & Drob (1989) found that norms can be established in group therapy that silence expression of negative experiences in the group and this can lead to drop out. Clinicians should guard against this by recognising when such a norm may be

developing, then making clear that negative experiences are a likelihood and proactively normalising and validating this.

The participants who dropped out of a group all valued that they were actively followed up by the clinic. In two instances they chose to take up individual therapy instead, and a third participant chose to reconnect with the clinic after taking part in this research. These participants are a self-selecting sample since they all agreed to participate in the research. However, these findings suggest that proactively following up those who drop out of groups and attempting to facilitate a positive experience of leaving the group is important. This fits with previous research that found that people who drop out later in group therapy can have worse outcomes than those who drop out early, perhaps because of the emotional impact of leaving an established group or perhaps because they were not offered other sources of help (Stiwne, 1994).

Limitations and research recommendations

This study sacrificed breadth of explanatory power for depth of understanding of a particular phenomenon. The study recruited a small sample from one clinic in an urban location in the south of England. Therefore, we must be cautious in generalising the findings to other psychotherapy or PBCT groups. Future qualitative and quantitative work is required to test the validity of this model of engagement with other samples. A future GTM study could theoretically sample from a broad range of groups to discover the engagement processes that seem to generalise across therapy modalities and target difficulties.

Finally, the study recruited only a few participants who dropped out from groups, and they may not be representative of others in the same position since they were contactable and agreed to participate. However, this is an important step forward since very few studies have elicited the views of those who have dropped out from group therapy in past research. Future

research might theoretically sample more from this population to densify categories relating to dropout.

Conclusions

The model that emerged from this GTM study theorises a recursive process where PBCT group members continuously invest in change as they evaluate its usefulness and safety. Safety and usefulness are initially evaluated based on past experiences and attitudes to the clinic approach and later through direct experience of the group. If safety is perceived to be compromised this may precipitate dropout. However, group member anxiety can be ameliorated through group structures that reduce uncertainty, encourage contributions from all members and establish universality around voice hearing early. Contact between sessions can help group members stay connected with the group process, feel cared for by the service and problem solve difficulties in collaboration with the service. Mapping the group's progress over the weeks may assist in challenging voice content and engendering a cohering sense of collaboration on shared therapeutic tasks. Normalising and validating difficulties with group content such as mindfulness can allow group members to persist in the face of these difficulties. Therapeutic effects seem to come from group content, for example finding evidence to question voices and learning mindfulness techniques; and interpersonal processes such as universality, cohesion, social learning and drawing hope from others coping. Both sorts of therapeutic effect can be internalised well beyond group termination. However, some are lost and the social support to maintain progress may be lacking, partly due to stigma blocking support seeking. The study is limited by a small sample size, particularly a small number of clients who dropped out from therapy.

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Section C:

Appendices of supporting material

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

APRIL 2017

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix A. Section A Search Methodology

Searches conducted on 5th January 2017.

Search strategy Medline, Psychinfo, Social Policy and Practice (Ovid)

1. (engag* or dropout* or disengag* or climate or attrition or compliance or attend* or participat* or terminat* or continu* or absen* or complet* or dropping out or treatment readiness or lapsed or lapsing or defection or defecting).m_titl.
2. Psychological engagement/
3. 1 or 2
4. group psychotherapy/ or encounter group therapy/ or adventure therapy/ or conjoint therapy/ or group intervention/ or psychodrama/ or transactional analysis/
5. 3 and 4
6. Remove duplicates from 5

Search strategy Cumulative Index to Nursing and Allied Health Literature (CINAHL)

1. (MH "Psychotherapy, Group+")
2. TI engag* or dropout* or disengag* or climate or attrition or compliance or attend* or participat* or terminat* or continu* or absen* or complet* or dropping out or treatment readiness or lapsed or lapsing or defection or defecting
3. 1 and 2

Appendix B. Adapted effective public health practice project (EPHPP) quality assessment tool.

* This has been removed from the electronic copy*

Original version available here: http://www.ephpp.ca/tools.html

Appendix C. NHS Research Ethics Committee Favourable Opinion with Conditions

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Appendix D. NHS Research Ethics Committee Confirmation that Conditions were met.

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Appendix E. Trust R&D Approval

* This has been removed from the electronic copy*

Appendix F. Participant information sheet (service-users).

Participant information sheet (group members).

Information about the research

Study Title: Voice hearers' and therapists' perspectives on engaging with group PBCT.

Hello. My name is Ciaran McHale and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.
(Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study).

What is the purpose of the study?
You are invited to take part in this study, which will ask people about their experiences of engaging with group therapy in the Hearing Voices clinic. We want to learn more about what makes it harder or easier for people to engage with the group therapy.

Why have I been invited?
You have been invited because you have agreed to attend the Hearing Voices clinic group therapy.

Do I have to take part?
It is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

What will happen to me if I take part?
This study would involve speaking to Ciaran McHale from our research team about your experiences of engaging with the group therapy in the Hearing Voices clinic. The interviews normally take around 40 minutes but you are welcome to end the conversation at any time. Sometimes we may ask to speak to you more than once, although this is unusual and you are welcome to decline a second interview. If you do choose to take part we can organise a location convenient for you and pay your travel costs.

We want to learn more about what makes it easier or harder for people to engage with the group therapy. We hope to use this information in the future to improve the way groups like this are delivered. This study will be submitted as part of a doctoral thesis at Canterbury Christ Church University. The interviewer will not be one of the group therapists and the answers you give will in no way affect the care you receive. If you choose not to take part in the study this will in no way affect the care you receive.

Expenses and payments
We are able to pay any travel expenses (up to £10 – paid in cash) that you have in order to take part in the study. Please keep a receipt of any expenses.

What are the possible disadvantages and risks of taking part
Occasionally people might find it upsetting to talk about engaging with the group therapy. The interviews may touch on recent experiences of hearing voices that might be upsetting to speak about. However you are not obliged to speak about anything that you don't wish to, and you can decide to end the interview at any time.

If you do feel you need urgent support at any time through the study you should contact your care co-ordinator or the duty worker for your community mental health team. If it is out of normal working hours (9am-5pm Monday to Friday) you can contact Trust on xxxxxxx

What are the possible benefits of taking part?
This research is aimed at improving the therapy available for voice hearers in the future. This will be a chance to contribute to improving services and making sure that people who use services are listened to.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

Part 2 of the information sheet
What will happen if I don't want to carry on with the study?
If you decide to withdraw during or after your interview this will not affect your treatment within the service. Data analysis will normally begin one week after the interviews. We would ask that you contact us before this time if you do not wish your responses to be used in the analysis.

Complaints
If you have a concern about any aspect of this study, you should ask to speak to me. Please contact 0333 011 7070 and leave a message for Paul Camic (a representative from Canterbury Christ Church University) or Fergal Jones (the academic supervisor of the study, also from Canterbury Christ Church University) and they will respond to your complaint as quickly as possible. If you remain unhappy and wish to complain formally, you can do this through anonymised

In the event that you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against trust but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you

Will my taking part in this study be kept confidential?
The interview will be recorded onto a digital recorder and then transcribed onto a computer. An independent transcriber might be used to transcribe some of the recordings. In this case they will be bound by a confidentiality agreement and won't have access to any personal information you submit in writing. The digital recorder will be stored in a locked secure place at all times and the computer data will also be protected from intrusion. The audio files will be destroyed at the end of the study. Anyone who takes part in the research will be identified only by code numbers or false names. You can request a copy of the interview transcript if you wish. The interviews will be analysed using a computer package by Ciaran McHale. Your recovery team will be able to see a record of your consent form so they will know you are participating in the study. We will only break confidentiality and inform your care co-ordinator or other parties of the content of any conversation we have if we are worried about your safety or the safety of someone else.

What will happen to the results of the research study?
At the end of the research I will write a report and the results may be published in peer reviewed journals and conference presentations. No research participant will be identifiable from any publications.

Who is organising and funding the research?
This study is a collaboration between Trust and Canterbury Christ Church University.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by London Fulham NHS Research Ethics Committee.

Further information and contact details

If you would like to speak to me and find out more about the study of have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 0333 011 7070. Please say that the message is for me [Ciaran McHale] and leave a contact number so that I can get back to you.

You could also speak to your care co-ordinator about any issues you have with the research. They have contact with the hearing voices clinic and will be able to see copies of this information sheet and your consent form.

Appendix G. Participant information sheet (therapists).

Participant information sheet (therapists).

Information about the research

Study Title: Voice hearers' and therapists' perspectives on engaging with group PBCT.

Hello. My name is Ciaran McHale and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.
(Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study).

What is the purpose of the study?
You are invited to take part in this study, which will ask people about their experiences of engaging with group therapy in the Hearing Voices clinic and therapists about their experiences of facilitating groups. We want to learn more about what makes it harder or easier for people to engage with the group therapy.

Why have I been invited?
You have been invited because you have agreed to facilitate one of the hearing voices groups.

Do I have to take part?
It is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason..

What will happen to me if I take part?
This study would involve speaking to Ciaran McHale from our research team about your experiences of facilitating the group therapy in the Hearing Voices clinic. The interviews normally take around 40 minutes but you are welcome to end the conversation at any time. Sometimes we may ask to speak to you more than once, although this is unusual and you are welcome to decline a second interview. If you do choose to take part we can organise a location convenient for you and pay your travel costs.

We want to learn more about what makes it easier or harder for people to engage with the group therapy. We hope to use this information in the future to improve the way groups like this are delivered. This study will be submitted as part of a doctoral thesis at Canterbury Christchurch University.

Expenses and payments
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What are the possible benefits of taking part?
This research is aimed at improving the therapy available for voice hearers in the future. This will be a chance to contribute to improving services and making sure that people who use services and clinicians are listened to.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?

If you decide to withdraw during or after your interview this will not affect your participation in the Hearing Voices clinic. Data analysis will normally begin one week after the interviews. We would ask that you contact us before this time if you do not wish your responses to be used in the analysis.

Complaints

If you have a concern about any aspect of this study, you should ask to speak to me. Please contact 0333 011 7070 and leave a message for Paul Camic (a representative from Canterbury Christ Church University) or Fergal Jones (the academic supervisor of the study, also from Canterbury Christ Church University) and they will respond to your complaint as quickly as possible. If you remain unhappy and wish to complain formally, you can do this through anonymised

In the event that you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Trust but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you

Will my taking part in this study be kept confidential?

The interview will be recorded onto a digital recorder and then transcribed onto a computer. An independent transcriber might be used to transcribe some of the recordings. In this case they will be bound by a confidentiality agreement and won't have access to any personal information you submit in writing. The digital recorder will be stored in a locked secure place at all times and the computer data will also be protected from intrusion. The audio files will be destroyed at the end of the study. Anyone who takes part in the research will be identified only by code numbers or false names. You can request a copy of the interview transcript if you wish. The interviews will be analysed using a computer package by Ciaran McHale. We will only break confidentiality and inform any party of the content of a conversation we have if we are worried about your safety or the safety of someone else.

What will happen to the results of the research study?

At the end of the research I will write a report and the results may be published in peer reviewed journals and conference presentations. No research participant will be identifiable from any publications.

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All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by London Fulham NHS Research Ethics Committee.

Further information and contact details

If you would like to speak to me and find out more about the study of have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 0333 011 7070. Please say that the message is for me [Ciaran McHale] and leave a contact number so that I can get back to you.

Appendix H. Consent Form.

Centre Number:
Study Number:
Participant Identification Number for this Study:

CONSENT FORM

Title of Project:
Name of Researcher:

Please initial box

1. I confirm that I have read and understand the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐
3. I wish to be contacted by post with the findings of the results when these are available.	☐
4. I agree to my recovery team being informed of my participation in the study	☐
5. I agree that anonymous quotes from my interview may be used in published reports of the study findings	☐
6. I agree to an audio recording being made of my interview which will be transcribed to text. I am happy for an independent transcriber to have access to the recording.	☐
7. I agree to be contacted after my initial interview by phone to be asked if I would be willing to conduct a second interview should this be necessary. I am aware that I can choose not to participate in a second interview.	☐
8. I agree to take part in the above study.	☐

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent _____ Date_____

Signature _____

Appendix I. Interview Schedule.

Please note this will be adjusted for group therapists e.g. Q1. would read "What do you feel prompted the group members to join the therapy group?" Furthermore it is anticipated this interview schedule will be substantially revised prior to the start of the study based on consultation with lived-experience consultants (who are part of a consultation group within the participating trust). The questions will also change in response to early data analysis in the context of an emerging theory.

1. What do you feel prompted you to join the therapy group?
   Prompts: Goals/aims

   Problems to overcome

   Curiosity

   Hopes about the group

   Loss/ gain of independence

   If someone else's idea, why did this person want you to participate?
2. Was there anything that made the idea of starting the group difficult?
   Prompts: Worries about the group

   Practical problems – transport, time of day etc.

   Worries about mental health services

   Voices

   Physical health problems
3. When you went to the group for the first time what helped you make the most of the session?
   Prompts: Therapist

   Other group members

   Group content

   Voices/ Symptoms

   Feelings on the day
4. When you went to the group for the first time what made it difficult to make the most of it?
   Prompts: Therapist

   Other group members

   Group content – mindfulness practice etc.

   Voices

   Issues with mental health services

Physical health problems

Feelings on the day

5. Once you started attending the group was there anything that made it difficult to keep going?
Prompts: Therapist

Other group members

Group content

Voices

Physical health problems

Issues with mental health services

Practical problems

Family/ friends

Substances

6. Once you were attending the group was there anything that made you want to continue to attend the group?
Prompts: Therapist

Other group members

Group content

Voices

Family/ friends

7. Was there anything that helped you put the techniques you learned into practice at home?
Prompts: Friends/ family

Other group members

Therapist

Techniques themselves

8. Was there anything that made it more difficult to put the techniques you learned into practice?
Prompts: Voices

Physical health problems

Friends/ family

Home life, housing problems, money, transport, addiction

Techniques themselves

9. Was there anything that made it difficult to engage with the group's discussions?
Prompts: Other group members

Group structure

Therapist

Worries about mental health services

Voices

Feelings on the day

10. Was there anything that helped you engage with the group's discussions?
Prompts: Other group members

Group structure

Therapist

Feelings on the day

11. Now you are no longer attending the group what would help you to move forward?
Prompts: Social/ vocational functioning

Managing voices

To apply learning

To engage with services

12. In what way did your prior experience of services affect how your engagement with the group?

Appendix J. Notes from service user consultation prior to adapting interview schedule.

* This has been removed from the electronic copy*

Appendix K. Adapted interview schedule.

Why do you think people might drop out from the groups?

Have you maintained any of the progress you made since finishing the group? If so, what's helped you to do that? / What will help people maintain their progress after the group finishes? If not, do you feel the group was still worthwhile or not?

Is there such a thing as "the right time" for this group? Would you have got the same out of this group at other times in your life? If you dropped out, what might make the group more timely in the future, if anything?

Were there any times when it was difficult to work with other people in a group? If you feel able to, could you tell me more?

What kept you coming back to the group? Were your reasons for returning different from session two to session seven?

People talked about their hopes for the group. A few of them were "hoping to feel normal again". Was this the case for you? If so, what does "feeling normal again" mean to you?

Do you feel you understand your voices better now? If so, in what way?

Did you like the mindfulness practice more or less by the end of the group? What brought this change about?

People have talked about their worries of being in a group: for example being judged by others or not accepted by the group. BUT other people said they just worried that group therapy wouldn't work as well as one-to-one. Can you relate to this idea? Please tell me more.

How are you in general with trying new things? What makes you anxious about doing something new? How did that play out with the group?

Some people said they were determined to make the most of the group because they felt that they **needed** to change**.** Does this idea resonate with you? Please tell me more.

Lots of people felt more at ease because it was a small group. Could you tell me what was helpful about having a small group?

Would the groups be better placed in an NHS location or a community setting? Why?

What do you think about the amount of time dedicated to each part of the group sessions? Would you suggest any changes?

Was it helpful to have done level one before you started level two? If so, what was helpful about this?

What helped you put the learning into place at home?

Would it be helpful for the hearing voices clinic to work with care co-ordinators to help people take the learning forward? If so what would be helpful about this?

Appendix L. Abridged Reflective Research Diary.

Reflective diary

13th March 2016

I've booked in my first interviews for next Thursday and Friday. I'll take this opportunity to reflect on some of the areas outlined by Birks and Mills in their grounded theory book.

Philosophical position

Over the time of the course at Salomons I have become more sympathetic to understanding many phenomena in the world of mental health as social constructions. I think that the interviews I conduct with participants will inevitably result in us co-constructing a narrative about their experiences of the group and will result in us privileging certain aspects of their experience over others. It will not be an authoritative account of their experiences since they will be too rich to be explained in any coherent narrative. That said, I believe that their experiences do exist as something real outside what they will articulate to me. We will create an imperfect narrative around something external that does exist. For that reason I can't call myself a social constructionist.

What I already know about this area

It's been a long time since I've read anything about group engagement or psychosis. I've concentrated on applying for ethics and doing my critical review over the last several months. There are still some thoughts prominent in my mind from the reading I did do almost a year ago now. I read about the group engagement questionnaire. They take a very broad view of what engagement is: engagement is about in session behaviours, attention etc. and applying learning at home, not just attendance. This makes sense to me. I'm interested in learning about group processes that influence attendance and I think I will need to be careful not to lead participants to identify particular processes. I'm aware that groups can form particular norms, perhaps around their explanations of their experiences, and any conflicting accounts may well be quickly silenced. I'm interested in the idea of people dropping out because they failed to experience a sense of universality early in the group. Yalom talks about outliers being at risk of drop out – those who disclose the most or least. I think outliers in terms of their beliefs about their voice hearing experience may become marginalised in the same way.

My expectations

I expect participants may have more to say about the things that helped them engage than the obstacles and they may locate the helpful things within the group and the obstacles as external barriers in their lives. I suppose I'm anticipating demand characteristics – social desirability to affect the accounts I hear.

I expect some of the issues that people highlight to be quite prosaic – travel issues, conflicting appointments, other responsibilities. I'll need to be careful not to try steer participants towards exotic explanations that interest me where more prosaic explanations are actually the most relevant to the participants.

My worries about the research

I'm worried that the transcription and analysis will take absolutely ages and that I won't find anything particularly surprising or novel at the end of all of it. I suppose I just need to trust in the process and I'm actually quite hopeful about the idea of coding line by line and hoping something novel or unexpected emerges.

I'm worried that some participants might find it difficult to communicate much about their experience, whether because of medication or because of mental health symptoms. I'm worried that the answers might be quite perfunctory and the interviews might grind to a halt quite quickly. I'm worried participants might just view the interviews as an evaluation of the groups and respond either to be nice or to pick a bone. I suppose that still doesn't mean that interesting things can't emerge.

19th March

I've now conducted my first few interviews. Some of the answers did make me think of established theory. Yalom's 'universality' came to mind when a few of the participants talked about the hopes they had for spending time with other people who hear voices. I was reminded of the research that research net did when one participant talked about the setting of the building, people in the corridor etc. All those physical, practical things before someone even sits down in the group, these are also very important.

22nd March

Interviewed two participants today. I'm again aware that I'm primed to hear some of Yalom's ideas coming through. "Disconfirming one's unique wretchedness" both participants talked about initial concerns about sharing their experiences for fear of judgement and then a therapeutic effect from experiencing a sense of "universality". I'm also interested in xxxx's feeling like he could learn from more experienced voice hearers and feeling hope because of how they've coped. I can't remember what theory this ties to but I'm sure I've read this in Yalom's book. Xxxx talked about feeling "dumped" by mental health services after an initial admission to hospital, with a sense of no input or interest shown in him, this was echoed by xxxxx. I find this sad. I was at A+E at the weekend and I felt this myself – processes were carried out on me but I left with little information and little sense of a person centred experience. This is a tiny microcosm of what it must be like to go through a compulsory stay in hospital with the sense of something life changing happening and then to feel like no-one has properly shown an interest in the details of your experience. It makes me sad and angry and upset for these two. This does remind me of the context of our study – people have limited access to talking therapies when they experience psychosis. I will have to remember this when I code: clearly the participants will talk about these issues but I shouldn't "over code" this and I need to keep open to other possible ways to code sections that seem to me to be about uncaring mental health services.

22nd March (b)

Just interviewed Xxxxxx who described a strong bond with someone else in the group. Bion's idea of pairing came to mind. Xxxxx seemed to have a strong shared identity with this other person based on their mutual diagnosis of BPD and felt her voice hearing experience contrasted with others in the group. Despite this she came to value a group identity and is lamenting the idea of the group ending. She navigated worries about becoming a group

outlier by reining back how much she talked. Another participant who valued that people are prompted to speak.

22nd March (c)

Transcribing Xxxxx's recording I feel like he may feel some pressure to show enthusiasm for the group and be a "positive participant". An example of the power differential at work? In our first meeting I remember him talking more about struggling with applying things at home and not thinking the work books were for him. I wonder how I can allow people to explore the negatives more without them feeling like they're being critical or feel like I'm judging them?

23rd March

Two of the participants have spoken about how sad and lost they will feel when the group comes to an end. It's making me feel a bit sad. And it's chiming with my pre-existing beliefs that often the content of such groups is the least of what's going on and what's important to the group members and forming that group identity is more important. It makes me worry about the long-term benefits of the group when that group identity has been dissolved. Having said that there is a monthly meet up group for "graduates" of this group. I'm aware that a lot of the positives of this group – reminder phone calls from the clinic, MP3 players, the "graduate" group are clearly good ideas and probably just come with research budgets. There's something there about the processes being good – all the additional bits rather than the "meat" of what happens in the group itself. Again I'm thinking of research net.

Xxxxx talked quite extensively about the difficulties of relating to people with different diagnoses and therefore, in her view, quite different experiences of voice hearing. She suggested that grouping people by diagnosis would be helpful. No-one else has mentioned this. Maybe I should ask people specifically about this? Has this come up for Xxxx because she strongly identifies with her diagnosis and is in regular treatment based around that diagnosis elsewhere? Would people with other diagnoses agree with this suggestion? Would other people with the same diagnosis more likely agree with this point? If so, why?

As I transcribe Xxxxx's transcript I'm aware this idea of BPD is very prominent in my mind. I can find myself framing things in terms of attachment and wondering about her attachments in the group, fear of abandonment, testing relationships. I'm imagining abuse and wondering how prominent safety must be as a concern for Xxxxx. I will need to be aware of this when I code and if I come up with codes that have a "BPD flavour" to them, I'll need to question how much the data is speaking that.

Xxxxx talks about spending four hours willing herself to go out and go for the coffee she had planned. Sounds like a lot of will power and commitment. So what would be useful questions to participants? How difficult is it to do the stuff between sessions? How and why do you do it then?

Two participants now talking about it as a social outlet and talking about a poverty of social interaction or activity for themselves or others. The group is fulfilling more needs that just those it's set out to achieve. And the other needs are not subject to a time limited intervention. Could the group do some harm for some people? Especially those with attachment problems? Social recovery. These thoughts though, certainly fit with my pre-

existing attitudes to therapy and group work – "common factor thinking". How can I take account of this in my analysis?

"We're the forgotten ones". Attachment considerations.

General mental health staff's ability/ willingness to talk about voices – continuation of some focus on them.

10th April

I interviewed Xxxxx and Xxxxx on 8th April. I'm transcribing Xxxxx' recording now and it occurs to me that people interpret difficulties/ facilitators of putting techniques into practice at home in a very practical way – i.e. mp3 players and work rotas. How can I put this so that they consider this question more broadly?

A lot of Xxxxx' answers focus on the practical and also talk about other people's reactions in the group rather than being in depth about his own. Xxxx does talk about positioning himself as a role model in the group and someone with one foot in a professional role – presumably one example of people in this particular group managing the differences and still eventually coming together with some cohesion.

Should have asked Xxxx why his previous experience of mindfulness didn't lead to any benefit but then he benefited quite rapidly after starting the group.

I get the strong sense from Xxxx' responses that he is being as positive as possible and isn't necessarily shooting from the hip. He may well be censoring a lot of his immediate thoughts. Interesting to bear that in mind – how much I'll be getting a sanitised account from people. Power issues?

Transcribing Xxxx's interview now. Who's theoretical pre-conceptions do I need to bracket? Just my own? Because this is obviously a participant familiar with theory around group dynamics and "cohesiveness" and "universality" get mentioned a lot. Interesting metaphor that almost seems to be about atoms moving freely and then bonding to form one big molecule.

Xxxx, like Xxxx, is also alluding to this idea about some people being in a position to take responsibility and look after others in the group. Struggling to very different degrees. What effect does this variability ultimately have? Bear this in mind when looking at transcripts from other people in that group.

Roger talking about NHS locations encouraging passivity, I can relate with A+E. Maybe worth asking participants about the impact of NHS locations?

Roger talking about eliciting apologies and presenting these to other group members – I'm thinking about stopping an absence norm developing. Need to be aware of that pre-existing theory on my mind.

16/04/2016

I'm finding Xxxx's description of battling the voices to get things done especially when they seem to have control (of his ability to think? And act?) and it's a struggle requiring grit and determination to get to the group etc. This is a common theme – "fighting hard" to get things

done over a prolonged period of time. What exactly does that battle feel like? And what facilitates people to fight it? When do they feel like giving up? What do they do then?

Emotional touchpoints or whatever they're called. I'm finding it really sad transcribing Xxxx's response where he talks about asking himself at times why do I have them? And not having a good answer. Just realising he does and he has to live with them. "Insight" in this way must be a very painful process. I read about "sealing over" vs the other recovery style and it sounds like Xxxxx is in the more productive style here but what allows people to stay in this painful position?

Universality – "I knew people had voices but I never met them". Being in mental health services for years but barely talking through details of voices with mh professionals, never mind peers. Surely we can arrange some universality for people on the cheap!

He's saying the mindfulness isn't good. My voices are worse when things are quiet. Can I clarify if he's saying mindfulness brings the voices on? These old worries of acceptability.

Theory – expressed emotion, impacting on how much Xxxxx can express himself at home. Worth following up with other people? There hasn't been much talk of support networks.

It might be interesting to learn more about the pacing of the group and not leaving people behind and not boring people. Generally positive feedback on that so far but it might be a good question to those who have dropped out.

27th April

Transcribing Xxxx's recording. His phone rings and the recording breaks when he talks about wanting to help other people in the group who help him. This touches on an area that others have spoken about. Helping and being helped. This might be worth following up.

I think I avoided quite an emotional moment (or something that I, at least, found sad. When Xxxx talks about hoping for a long, long time that something would help him. He doesn't know how it would work but he just keeps "hoping and hoping". What are people's relationships with hope and coming into therapy? Some people choose not to hope at all, perhaps because of previous hopes dashed. Xxxx did and Xxxxx did, though what he initially hoped for has been scaled back. How are hopes managed?

Xxxx's comment on the facilitators "like we're doing it together". I introduced those words but I can tell they hit home. Xxxx said this is what he's trying to do by using "we" all the time. Collaboration. "Yea, we're doing it together. I know he's not obviously at home with me but- because when I do it at home on my own – well if it fails I can see him next week, next session and talk about it". Non-judgemental, not taking a one-up position, not like an experience of school – see below.

""oh you can't because we've only got fifteen minutes left until we finish" like other people." Who are the other people? Other MH groups? Experiences of education?

It sounds like Xxxxx has had a lot of experiences of being disappointed by interventions or contact with MH services, or medication not working. His hopes were high in the way he expressed them – for it to "change my life". And it's only when he talks about the numbers recorded each week and perhaps thinks back to the homework etc. that he seems to feel in the interview, "wait a minute it is working and things have changed for me in some ways" The

value of monitoring goals/ progress in-sessions? And setting specific SMART goals? In general what process do people go through in monitoring their own progress?/ Decide if it's working or is worth sticking at in any way?

30th April

Doing Xxxx's transcription and she talks about learning from other people's techniques. Do people take ideas on board and apply them more if they come from other group members? How does the facilitator facilitate peer to peer learning and how is this prioritised alongside PBCT techniques? If group members do prioritise learning from peers how do they decide what to try out first? More generally, why do group members try out one technique and not another? What generally makes them more likely to try something out at home? Some kind of process of identifying with group members/ the facilitator before taking anything on board? Identification is a pre-requisite for social learning.

Xxxx again talking about the facilitator getting alongside the group – collaboration rather than hierarchy. This in itself must be important for encouraging peer to peer learning. How does the facilitator manage this? What do group members notice?

Xxxxx highlighting the importance of everyone participating – trust?

Mindfulness: remembering it, life getting in the way, making time for it, using it at times of acute stress and to help with sleep – differences from the recommended applications to the reality of what people do?

"But I think I've come to the end of my tether really. I have to do something". – echoes of others like Xxxx.

Xxxx like many others talking about a really long, painful battle against the voices to make it to the group. A lot of motivation needed. I'm feeling some admiration listening back to this recording. Xxxx's determination comes across.

Theoretical memo? Sabotaging voices increases difficulty of making it to the group which means more coping strategies have to be drawn upon. A lot of motivation needed: I've done the other bits already, I'm desperate for change. And then the process of the completing the group becomes a real source of pride it seems from different interviews. Hope can be drawn from own achievements and witnessing others. What happens to hope after the group ends?

What is the role of humour in the group?

Letting referring clinician/ the clinic down as motivator. Sense of scarcity of the resource making it seem more valuable.

Transdiagnostic. An issue, not an issue?

Debbie talking about feeling back at school but then a positive, non-punitive intervention from Roger helped. Not getting left behind by kind of getting dragged along in a kind way.

1st May

Fears of the group ending really is a strong theme. How do I build the sense that MH services aren't doing a good job of witnessing/ validating the voice hearing experience outside the group into my theory of engagement in the group?

Xxxx seems to regard it as somewhat of a personal issue but she's proud of working hard, she wants that recognised and part of the group ending seems to be losing that validation of a job well done – for that reason she wants a memento of the achievement ("transitional object?") How can the group honour the ending in a useful way with these ideas in mind?

2nd May

Transcribing Xxxx's recording. It's clear in the interview Xxxxx has difficulty with working memory and generally in expressing precisely what she means. She also has hearing problems and needs transport to make it to groups. A lot of bespoke adaptations are needed for different people and again there is the issue of keeping everyone on board with fewer and greater needs. Interestingly helping others and imparting advice has come up again as a theme and it has come up as much from people who on the face of it struggle the most with voice hearing etc.

"the lady from the hospital in Xxxxx, she would ring to text me or leave a message, which I thought was quite good because they didn't have to but they do and it makes you feel much brighter inside".

10th July 2016

I've just come back to the analysis after a long break to complete my PPR. I'm sure it will take a little while to "get back into it" but I'm excited to do so. I want to move it forward substantially in the next month or so – I want to be able to move on to part A in the knowledge the analysis is more or less done.

I'm looking through all the codes (titles only at this stage) and thinking of ways they may be linked: people comparing this group to previous experiences of groups (MH services more broadly?) In various ways, internal factors in engagement – e.g. determination to see it through and maximise one's engagement, a sense of "needing" to do something now – this is a whole class of important factors outside the circumstances and delivery of the group itself,

23rd September

I just returned to analysis in the last week. It's always difficult to get one's head back into it after an absence. I've started grouping the codes in Nvivo into categories/sub-categories. I'm finding the don't fall neatly into Category> Sub-category> Codes. Often more levels in a hierarchy make sense. I'm not sure if that's ok at this stage? The process of doing this still brings new insights and ideas, which is very enjoyable.

6th October

I interviewed Xxxx (a facilitator today). I was struck by how many reservations he had about the effectiveness of the intervention, the acceptability of encouraging people into the group etc. It's quite a different perspective from the largely positive things I've heard to date and it reminded me of the fact that I recruited from two seemingly very successful groups and only spoke to one person who dropped out. I'm going to attempt to remedy that by speaking to a few more people who dropped out. I also want to speak to another facilitator who isn't a member of the hearing voices clinic. Maybe there are lessons to be learned for the clinic in terms of how the therapy is regarded and delivered by clinicians in routine practice.

Today I also booked in a few follow-up interviews with previous participants. I'm really interested to hear their thoughts on a few specific questions but also how things have been since the group ended. The drop-in sessions never happened and I know how anxious people were about being left with nothing. This could be another valuable learning point for the clinic and might give the study a unique perspective – qualitative follow-up after the intervention period.

Xxxx is talking about someone who left at half time during a group session and "we never saw him again". This is in marked contrast to the level of detail Xxxx knew about the journey of people who stayed and those who dropped out. Perhaps a lack of communication between clinic assistants and facilitators in routine practice?

I'm also aware that I felt some annoyance and resistance to (what felt like) Xxxx's negativity. This might bespeak the fact that I am identifying very closely with the research clinic and don't want to hear too much criticism. I'll have to be careful of this when I come to incorporate the challenges of engagement into the theory.

Remember – challenges of translation into routine practice, scepticism about transdiagnostic approach and symptom focus, how people are after the group ends, lack of referrals due to team attitudes

13th October

I'm transcribing Xxxx's interview and he feels that universality is comforting right in the moment but doesn't have any longer-term effects, since people's struggles with the voices are still the same. It will be very interesting to ask participants, now the group has finished, what the enduring positives are, and if that experience of universality still helps them now or not.

I'm also picking up from Xxxx the idea that hopefulness in others coping and universality etc. need to then give way to personal experience of change for their positive effects to endure. Theoretical code?

20th October

I've recorded and transcribed a few more interviews. I'm struck that difference isn't just something that presents as a difficulty and needs to be "managed" but enriches the group and allows better engagement. E.g. more talkative people and less talkative people probably have quite a symbiotic relationship. This will need to be taken better account of in my analysis.

A few people have talked about worries of judgement or "not wanting to talk about it" is in general a barrier to seeking help. This is something to incorporate into the theory.

I attended some training today which spoke about how people really try their best to avoid talking about voice hearing and it's only "the wheels coming off" that might drive them to do it. Is this related to the concept in my analysis about feeling they need to change and the motivation that brings?

It seems people get a very powerful benefit in the early stages of the group from that sense of universality. And this might motivate them to "stick around" and "be curious". Despite what one of the group therapists said there does seem to be some ongoing benefit of holding on to the memory of that but Xxxx talks about the need to keep contact with people and have an

ongoing experience of community and keeping base with others suffering with some of the same experiences. Quite apart from this, the two participants I spoke to for a second time seemed to get some ongoing benefit from internalising the cognitive model, from keeping up with the mindfulness practice and internalising this way of approaching their experience at key times. Both participants also seemed to hold on to some new learning about the nature of their voice hearing – for example both were continuing to realise more deeply post-group how much their voice hearing was tied to their stress levels.

3rd November

I'm aware as I transcribe the last few interviews that I've gathered quite a lot of data on the pros and cons of NHS vs. community venues. This would be worth drawing out in the analysis. Also the last two participants talked about motivating a good experience at level one is. Others have sad the same. Perhaps a clinical recommendation might be the need to harness that motivation rather than letting it run stale before Level Two.

Some social psychology theory is coming to mind as I do this transcription. Xxxx talks about how she could look to those "further on than me" and draw hope and those further behind as evidence of how far she had come. She also talked about perceiving them all as similar to her in some respects. This reminds me of the idea of downward and upward social comparison. And that that sense of hopefulness relies on perceived similarity. So again universality is needed for some of the beneficial effects of the group.

Interesting that I've investigated Xxxx's hunch that the common factor stuff doesn't last in the long-term and the patient participants seem to feel the opposite.

I've just coded something as sealing over but this seems more like a condition for sealing over – when someone has a lot of other things going on they may judge that the time isn't right to engage with the group and bring up difficult experiences.

Appendix M. Audit trail: categories, codes and example quotes for early iteration of the analysis.

Core category: Learning about voices in a safe environment		
Sub-categories	Initial and focussed codes	Quotes
Category A. Reservations about starting therapy		
Interpersonal concerns	Fear of being judged	P2/L 76. "because I was worried about saying what the voices say to me because I felt like I'd be a bit judged from the group."
	Worrying about seeming crazy	P7/L55. "I was thinking what they gonna say if I say something of my experience they could maybe laugh or think, "she's crazy""
	Worrying about being rejected	P6/L41. "So just some worries about feeling accepted, about making a valid contribution and my contribution being respected."
	Performance anxiety	P9/L35. "Well I didn't know who was going to be there. I don't like groups, I don't like- I'm not very good with people I don't know. I don't like talking. So I was worried about who was going to be there."
	Undesirable others	P12&13/L116. "Yea I suppose if they were disruptive to the group I was thinking and if other people would just be too ill or would disrupt the group somehow or didn't want to be there."
	Exposing private experiences	P10. L63. "So I think people have these expectations that it's going to be a reveal all type of experience (…) that in itself could be a very

		embarrassing and shameful experience."
Not hopeful of change	Individual needs not being met in a group	P5/L114. "I was worried about how long I'm going to be in there for because I can't do long periods just talking because that's when my concentration goes."
	Large dropout from group therapy	P4/L145. "it's always a worry that it's a huge group because it's such a big fall out of groups anyway."
	Incompatible explanatory model	P10/ L69. "So I think people might have this idea that psychological therapy doesn't really get to the core of the problem, but it's just peripheral to the main treatment, which is medication and monitoring. So the idea of a group treatment program when they're already receiving medication is: well why would I do it?"
	Previous groups haven't worked	P5/L137. "at first I thought "it's not going to make no difference" because the things what I done before with the mental health team didn't really work."
Feeling nervous about starting something new	Worrying about panicking in new setting	P2/L71. "I was worried, because sometimes with new things I get anxious and panicky and I was worried I was going to go to it and be panicky"
	Nervous about new physical setting	P13/ L128. "I think for me the main worry was geographical because I was travelling independently on the bus and the place that I was going, I'd never been to before and I knew that it was really hilly there <Taylor uses a wheelchair> and I

		wasn't so much worried about going downhill, but if I miss it or overshoot or whatever then I'm going to have to try get up the hills."
Worrying about repeating negative experiences of services	Negative interpersonal experiences in previous groups Not feeling connected to previous therapists	P4/ L148. "It makes me feel vulnerable. There's a part of me, I don't want to get laughed at, I don't want to feel humiliated, which is sometimes in past groups I've felt." P8/L155. "Martin? He was really difficult to understand what he was talking about(…)so I thought joining this group, is it the right thing to do?"
Category B. Initial Motivations		
Hopes for voices	Hoping to gain control back from voices Hoping to understand voices Hoping to get rid of voices	P7/L28 "Yea that I can decide when I want to speak not only the voice decide when the voice want to speak." P2/L3 "I joined it because I wanted to understand my voices better" P2/L49 "At first I thought it would maybe get rid of it altogether."
Hoping to feel normal	Hoping to expand horizons Stop self-harming??? (Q)	P5/L213 "I don't know how long I've got left until I die, so I want to improve my ways, I want to make something of myself. Or I want to say, "look, I've been here" or "I've been there" or "look, I've got loads of friends"."
No-one to talk to about voices	Not wanting to worry loved ones	P5/L100 "my family keeps telling me to come out with it – what my voices are saying, what I'm worried about. But to me I don't to because I don't want to make them get worried."

	Worrying about stigma in personal life	P2/L82 "I don't really talk to many people about it because I'm worried they're going to judge me and avoid me because of it."
	Feeling abandoned by other services	P2/L303 "I'm glad the group's there really to be honest because I did feel like I was left to get on with it. Because I was in hospital, nearly three years ago, in the psychiatric ward and I had voices and psychosis and everything and then when I came out of hospital it was quite scary because they left you just to go home and get on with it."
	Seeking universality	P4/L14 "My main aim really was to be less isolated and to actually hear about other people's experiences and whether they would resonate a bit with my own. So that I didn't feel so lonely with it because the voices are quite terrifying for me."
	Group allowing catharsis	P5/L226. "It's just like you want to get it all off your chest because if you ain't got nobody to talk to and you don't want to worry people you keep it into yourself."
Felt need to change	Voices driving self-harm	P2/L198 "I need to learn about it more and learn a way of coping properly. Because I don't want to keep causing myself harm and going to hospital."
	End of my tether	P4/L69. "I've been on mindfulness courses before and my attendance has not been as regular as this group. But I think I've come to the end of my tether really. I have to do something."

	Voices causing intolerable distress	P4/L82 “it’s just at night time they seem to chatter more loudly and they’re screaming at me and with that noise going on in my head I can’t think because it’s so loud and they’re so negative and they’re calling me names and it makes me feel very paranoid so if I don’t break the cycle then they’ve won haven’t they really? “
	Doing it for family	P5/L235 “And I can’t go downhill because I’ve got nieces, I’ve got little ones”.
	Grabbing a scarce opportunity for change	P5/L212 “I have to. Because if I don’t do this I’m going to be like this the rest of my life and I want to do things with my life”.
Category C. Building bridges to therapy		
Giving it a go	Deferring judgement	P6/L61. “I tried not to have too much introspection and judgement before going. I think just letting the experience just talking for itself.
	Not building expectations	P3/L17 “I didn’t really have any hopes or expectations. I was just, “I’ll go along and see what it’s like”.
	Initial short-term commitment	P4/L126. “So part of me was not quite sure about this but I’ll go to a couple and see what it’s like and that’s all you can do isn’t?”
Services building bridges to therapy	Attending in appreciation of clinic’s efforts	P8/L202. I: “And would that stop you going to the group? P: Well in one sense it would, in another sense it wouldn’t if they’ve gone to all this effort then you

		would go rather than not go."
	Clinic expectation to give it a go.	P1/L207. "But always encouraging people to make the informed decision. "Come along, just once or twice, have a look, get a feel, see if you're initial feelings change over the course of the meeting"."
	Flowing with clinic levels	P1/L5. "So is there a sense of the group being Hobson's choice? If you want more therapy in the voices clinic then you need to go into the group."
	Motivated by positive experience at level one	P7/L119. "Because I got good experience with level one therapy. I enjoyed that one and why not try the group therapy."
	Positive experience of other groups	P12/ L125. "Yea I've done various groups at the <service> and it's all been fairly good so I was imagining it would be like that really."
	Socialised to psychological understanding of difficulties	P10/L94. "someone in the group who did really well(…)he had CBT before(…) so he was kind of on board with the theory.
Category D. Settling in		
Reducing uncertainty	Sizing up before jumping in	P2/L143 "(on the first session) I sat there quite quietly, not talking really and just trying to size it up what was going to happen."
	Group structure helping orientation	P6/L115 "I think for some people having that structure of having the same pattern and routine every week might have been useful. You know what to expect, don't you? So that probably lowers anxiety."

	Familiar NHS location	P2/ L153. "when I come here (to NHS building the group was located in) I do feel safe. If they'd said it was somewhere that might have put me off a bit because I struggle going to places I'm not too familiar with."
Relaxed informal atmosphere	Hospitality and informal conversation	P9/L189 "it all seemed quite clinical I suppose(…)Maybe the first time you just, I don't know, have a cup of tea and maybe talk about what's going to happen in the future rather than just go in and do it."
	Collaborative spirit supporting motivation	P4/L24 "I know that when I go to the group I've got that supportive atmosphere and that it doesn't feel like a hierarchy from Roger to us."
	No rigid and formal rules	P5/L192 "if we need to go out because it's getting to hot, he will let us out, because he's not going to say "oh you can't because we've only got fifteen minutes left until we finish" like other people. He don't do that."
	Humour taking the seriousness out of it	P4/L112 "I: Yea, why's the humour good? P: It takes the seriousness out a bit. Where obviously it is a serious issue, to have the odd joke thrown in or something said that makes it a bit more light-hearted I guess."
	Mindfulness relaxing people	P7/L95 "I: And did anything they did, help you get comfortable? P: Yea, yea. Because we did the mindfulness at the beginning

		when they start. And that made me feel relaxed."
Feeling safe	Feeling held by caring clinical staff	P3/L198 "The two people that run it, they're quite nice people, so they make you feel welcome. Even if you just stand up to get a drink they'll ask you are you ok?(…) if you do leave (…)they wait for a bit and they'll go later on and see if you're ok.
	Permission to leave the room if anxious	P2/L17 "Basically on the first group I said "if I get anxious" and they said if I get panicky or anxious I can just leave the room and that's fine so that put my mind at ease a bit."
	Feeling safer in a small group	P5/L179. "And it's not a big group, it's just a small group and I handle that I do. But if it's a big group I wouldn't say anything but a small one."
	Group rules creating safe atmosphere	P4/L139 "So by going to the group you don't get a choice in whether you're validated or not because you're involved in a group and so therefore the ground rules are up there."
	Universal responsibility to contribute	P2/L96. "Because at first when he asks people to talk, no-one talks. We all sit in silence and then in the end he'll just pick someone out and ask them if they've got any views. And gradually he'll pick everybody. He'll go around the room, so you

		all get a chance to talk. I used to sit there quiet, but now if he asks a question I sometimes answer first if I can."
	Settling in before working	P1/L128. "And there's often a group rule that says, "contribute as little or as much as you feel comfortable in doing". Yet that sense in which, once you've signed up to the group- so I always say that sessions one, two and three, people are just dipping in and seeing if they're going to stay and after session three if people have effectively said they're going to stay, then they roll up their sleeves and they start working."
	Clinic setting realistic expectations	P1/L304. "And we've wondered whether we should be more active in setting an expectation that people will do more between sessions but we're always pulling back from that with this client group. We wouldn't want that to become oppressive and lead to disengagement and we always acknowledge that people's lives between sessions are often quite difficult. People often haven't got the stability domestically or relationally or financially or even quite often physically they haven't got that stability during the week."
	Extrovert group members leading the way.	P11/ L125. "Probably because he was quite honest other people felt able to be a bit more honest. And I think probably because he had lots of struggles people felt a bit

		more ok to talk about their own struggles."
Discovering universality	Universality facilitating openness	P2/L83 "But when I'm in this group you feel part of the group because they've all got the same thing, it helps you to talk. Get all your thoughts out that you've bottled up."
	Bringing voices into the open in-session	P1/L265 "if voices are talking in a mindfulness practice we'll elicit that during the enquiry and just consider how people responded to voices."
	NHS location creating sense of universality	P8/L185 "Is this a good place to have the group? M: Yes it is actually. I: Why? M: Well everybody is here for the same reason, even the ones that don't go to the voices clinic I should think"
Category E. Difficulties with sustained engagement		
Negative experiences of mindfulness in-session	Feeling unsafe to meditate with relative strangers	P3/L184 "D: I felt very unsafe. I couldn't shut my eyes. I kept looking for the door. Because with my borderline I have to always look at the door. I have to always feel safe. I know that I've got trust issues. So I just thought, "well fuck it". I just thought, "I'm running out of the room". So it was really hard."
	Feeling disconnected from the group	P9/L79 "And what was that like then sitting with your eyes open with this relaxation thing happening? T: I just felt really awkward because everything else was doing what they were supposed to be doing and I wasn't."

	Mindfulness triggering worry	P5/L79 "I: So you'll be sitting doing the mindfulness but you'll be worrying about stuff. R: Yea sometimes I can drift of into my own world and sometimes I think it's not really helping me. I'm just drifting off or I'm getting more worried."
	Mindfulness and feedback too long	P3/L26 "we're not very good with meditation anyway. So I just sat there fidgeting. Just thinking, "Oh god hurry up!" It was alright I guess but I think you could do a lot more in that time."
	Unable to concentrate during mindfulness practice	P5/L67 "the mindful reading what we do, every time we do it first. I can't really concentrate properly."
	Feeling unable to give negative feedback on mindfulness in-session	P5/L95 "But I don't want to tell Roger because I don't want to hurt his feelings so I don't tell him I just say, "it helps a little bit"."
	Mindfulness practice triggering voices	P1/L268 "And then there are rare circumstances where for example mindfulness practices for one patient who dropped out were actually triggering voices and we tried to work with that but weren't able to."
	Mindfulness triggering flashbacks	P13/ L62. "The last time I went, the flashback I had and the dissociation with it was so bad I couldn't leave the room even."
Personal barriers to applying learning outside group	Poor concentration interfering with home practice	P5/L90 "And my concentration has gone anyway, I can't really concentrate. I can't even watch a movie at home. I have to get up and do something else"

	Mood interfering with home practice	P7/L289 I: "what's going to make it difficult to apply this? P:Uh because sometimes you don't always have best day. You can be more stressed or you can feel tired or something by voice."
	Voices interfering with achieving goals	P3/L284 "I wanted to go for a walk Saturday. The voices got too- really really bad for me. So I didn't go even though my carer wanted to come with me."
	Memory problems interfering with applying learning	P5/L145 "when it comes down to important things I do try to take it in but it don't mean I'll remember it."
	Instability in home life an obstacle to applying learning	P1/L307 "People often haven't got the stability domestically or relationally or financially or even quite often physically they haven't got that stability during the week. They're often having to deal with lots of other day to day challenges to."
Personal barriers to group engagement	Missing a session making it harder to return	P4/L152 "That's why because the more you miss the harder it is to go back. So the next week was hard. It would have been very easy for me to have not come."
	Mood interfering with group attendance	P2/L40 "And it can put your mood down and make you feel like not going out and I stay indoors a lot."
	Cognitive barriers	P8/L114 "And I didn't understand the first few weeks, though you've got that thing that's got the date on etc. And then some of the things that Roger had put on the wall, the writings and

		things, I thought, "I don't really know what that's about"."
	Physical health problems interfering with group engagement	P4/L176 "I have sleep apnoea, so there's times where I will fall- if I've got all warm and we're in an environment where I'm actually not contributing at that time I get really warm and sleepy."
	Voices interfering with group engagement	P2/L147. "He was doing the mindfulness and sometimes- the voices pop up every so often and they're saying "don't listen to him" and things. So it's hard to focus on it(…)Saying that he was going to hypnotise me and things like that. And I was feeling a bit anxious about what was going on."
Personal barriers to any help-seeking	Sealing over	P4/L225 "I've done a few courses with the mental health that, particularly mindfulness ones, whether it was just that I wasn't ready maybe, or whether it was just incredibly wrong and I just didn't really understand or maybe really want to understand it at that point. I think when you're hearing voices you don't really want to admit to that, because you worry about what people think."
	Struggling to keep hope	P5/L156 "Because I've been hoping something would help me for a very long time because I had my voices for ten years and every psychiatrist, everything else. And then I'm trying to hope it can help me properly and it don't. And now- I just

	Low energy levels	keeping hoping and hoping really." P12/ L6. "I think I must have been doing it in winter because when it was finished it would be dark and so it was near the end of the day and I was tired and it was such a struggle to just get out the door and just do it anyway."
Difficult interpersonal experiences in the group	Feeling not understood by other group members	P3/L108 "she doesn't really get when we say that we can't help but listen to them. She's like, "oh well why don't you just, just tell them to go away" and it's like, it doesn't work like that for us."
	Distressed by views of another group member	P3/L138 "and she says things like, "oh just listen to the voice" So I'm like, "well my voice tells me to kill people". She's like, "it doesn't matter, you can just go to church and repent." So it's like, "no that's not helpful". So that stopped me from going one week.
	Interpersonal anxiety	P10/ L276. "So she'd come into the group, say hello very sheepishly, sit down and that would be it. She'd almost freeze throughout the whole session(…)So it became apparent from quite early on that this person probably wouldn't benefit very much from the group."
	Disclosure experienced as too threatening	P10/L43. "An educated guess would be "yes, people might have felt too exposed". A couple of people did drop out of the group I did who was very quiet and you can kind of

	Perceived problematic difference	surmise that it was too exposing for him." P13/ L179. "I think I probably felt a but different right from the very beginning because I think everyone else was getting on really well with the material or finding in some way that it was helpful and I wasn't."
Practical issues	Physical location of the group problematic	P9/L64 "Yea it was really busy and noisy (in the building) and I started to get really anxious. Because the bus stops down on the (name of road) and I had to walk through the town."
	Technical problems	P6/L173 "We were given a Walkman but they weren't very good, mine broke within the first couple of week."
Category F. Managing difficulties and renewing commitment		
Managing difference	Building bridges across difference	P1/L151: "One of them who was quite cliquey to start with and wanted to identify with a clique and then stepped out of that clique and really embraced the other group members. That patient I think was instrumental in building bridges."
	Compassion for group outliers building cohesiveness	P1/L154 "I think the other patient who was quite eccentric and quite on an island of their own, I think against the odds, or against expectation, actually stayed with the group and turned up every session, and the group started to look after her and that felt quite cohering."
	Pairing	P3/L256. "I know one lady there and we're really good friends and that helps us

		because we talk outside and we try to give each other encouragement to go to the next group. So that's really helpful."
	Regulating behaviour to fit with the group	P6/L275. "At some points I thought, "well let other people talk and think and see what they have to say". And by being a bit quieter at times allowed some of the shyer people to come forwards."
	Facilitators regulating outliers' behaviour	P10/L288. "And when she was asked a question she just sat there in silence. So it was very, very awkward and that clearly had an effect on the others. So we asked her to leave. So that was a clear dropout but one that we instigated. She was just inappropriate for the group."
	Unspoken difference	P11/L111. "a lot of it was unspoken, we didn't really name it further than that in the group. I think we more decided it would be best to keep it to the subject matter of the sessions rather than try and delve into whatever could have been going on between them."
	Underlying commonalities driving respect.	P4/ L164. "I don't know what other people's diagnoses are apart from one week one of the participants mentioned it and we all found we had something different but similar trait the whole way through but there was no aggression in the group."
Keeping everyone connected with the group process	Contact with clinic between sessions	P2/312. "they do ring you up and ask how you are and things. It feels like they are

		concerned about you, so it's reassuring."
	Keeping up with the group's shared knowledge	P2/L208. "Yea, when I missed that sessions I felt quite bad because I didn't want to lose out on what people were learning, so I was worried I would miss out on something important that I needed to know but when I went after missing one Roger quickly went through what they talked about the week before. And that helped me catch up."
	Holding absent group members in mind (Q)	"It also helps us to know, it helps us to elicit apologies in a sense. So if someone's not going to be there, we just need to know why, that they're alright and (…) group members we don't worry about that other person because we know that they're at the dentist."
Interpersonal support to apply learning	Group members supporting one another outside the group	P3/L256. "We'll talk a bit more about it and try and say, "OK you try and do that and I'll try and do this". And try and give each other little things to do."
	Support from other services to apply learning	P3/L276. "I live on my own and I've got an assistant as well. So I can talk about it with him and I told him about little things and I say to him, "I want to do this and that" and we'll do it."
	Support from family to manage difficulties	P2/L183. "I was panicking because my voices were really strong and I felt that I was going to be overdosing and dad came down from London, picked me up and took me back to his house."

Determination through adversity	Acceptance and commitment	P5/L48 “So I understand about my problems. Sometimes I don’t. Sometimes I ask myself what do I have them for? But obviously they’re meant to be because if it didn’t meant to be I wouldn’t have them but it’s meant to be so I’ve got to learn to live with them. Everyone else has to live with their problems and I have to do mine, so.”
	Battling to achieve goals	P3/L293 “when I went for my coffee. I managed to go but it took me about four hours to get out of the house and go but I got there in the end. So it just takes a lot of energy to keep fighting them.”
	Determined to maximise engagement in group sessions	P4/L129. “And that was important that I wasn’t going to just blend in with the surroundings and get lost on the way. That I was actually going to participate with this. “
	Persisting with new learning when frustrated	P5/L270. “I try it and if it don’t work, well I’ll move to something else. But I don’t just try it out once and then say, “well I’m not doing that”(…) Because nothing can work only in one time, it takes time.”
	Overcoming the voices to engage with therapy	P8/L46. “M: I don’t know I think they were just trying to stop me coming sort of thing. I: Yea but you managed to come anyway. M: Yea. I: How did you manage that? (…) I think I was saying to them, “you know it’s not going to work if you

		keep asking me to do things like leave etc.””
Clinic responding to obstacles	Clinic learning from problems	We do have work books that we give to patients at the beginning of therapy. My sense is that they probably don’t get used(…)we might want to make these materials more like a work book rather than a series of sheets.
	Group timing helpful	P4/L92 “So to actually force myself out is difficult but being the time that it is, it’s not as difficult as it could have been.”
	Clinic responding to individual needs	P4/L175. “I’ve had to say to Roger on a couple of occasions, “I’m really tired”. Because I have sleep apnoea (…) and at those times he pulls me into the conversations almost all conversations just to keep me going.”
	Phone calls addressing practical problems.	P1/L235. “And they’ll be in contact the day before the next session, “are you ready for tomorrow’s group? Got your transport arranged? Everything ok?””
	Clinic inspiring hope in change	P1/L262. “So we talk about how voices can sometimes sabotage your attempts to get help and then we might wonder for a moment why that is, “maybe voices don’t want you to get stronger?” So voices do try and sabotage.” P4/L89. “Well they’re good at wanting to sabotage it because it’s not in their best interests for me to go. So they’re quite good at putting the thoughts and the voices saying, “oh well

	Clinic drawing attention to successes	you're not really feeling up to it." P1/L265. "We'll elicit that during the enquiry and just consider how people responded to voices when they were around and whether they were able to bring their attention away from voices and what that means about them and voice control."
Category G. Dropout (Q)		
Interpersonal factors	Group outliers dropping out.	P1/L226. "I remember one or two patients dropping out of earlier groups and there was just that sense of, "I don't fit in here. You're not quite like me". So whilst the majority might get that sense of universality I think you can get almost the opposite. "
	Difficulty with another group member.	P 13/ L68. "I didn't want to hear about the experience of this lady particularly who had a very religious experiences with her voices. It was just a bit too triggering. So I didn't continue."
	Difficult being around others in a group	P10/L15. "I think maybe being in a group is very hard for some people with psychosis. Hearing voices, paranoia. So they may well drop out of a specific voices group, because just being around other people can be difficult."
Personal factors	Anticipatory anxiety intolerable	P9/L131 "I didn't sleep because I was worried about going because I kind of knew, I kind of felt I really should go and the last time I went I was ok so I should go but then my anxiety was

		getting really bad and I was having flashbacks of all the things I didn't like from the week before and just worrying really about what if I don't like it?"
	Chaotic lifestyle	P11/ L9. "I think for him just organising himself to get to the group was quite difficult: finances, getting enough money together to get a bus and I think he just had a fairly chaotic lifestyle so that made it hard so he came occasionally but then after a while he just stopped coming."
	New commitments	P11/ L5. "o there was one woman who didn't complete for very positive reasons. She got a job and wanted to commit her time to working and I think the job clashed with the group."
	Initial motivation weak	P10/L3. "Why people drop out? (…) they started the group half-heartedly. That they were asked-stroke-encouraged to do the group. That they weren't that motivated to begin with."
Group content	Members dropping out because of in-session mindfulness practice	P3/L33 "But some people have left because of it (mindfulness) so it can't be that great."
	Group model incompatible with patient's model	P10/ L8. "Another reason is that they might have a very different approach to their illness, to the problem they've got, than what the group promotes. So for example somebody in my group, actually he dropped out, he had a very medical perspective on his psychosis. And he would say during the group, "if you

		just take your medication you'll be ok."
Category H. Working		
Using techniques at home	Trial and error with techniques	P2/L217. "what I did for myself was to put music on(…)And sometimes that doesn't always work. Some music to me it triggers my moods but I listen to the mindfulness recordings that they did and that helps to calm me down a little bit."
	Using mindfulness to relax.	P2/L214. "He's given us these little MP3 player things and that's got mindfulness recordings on it. Sometimes I listen to that when I'm at home. I listen to it in the afternoon. Or sometimes when I've gone to bed I've played it in bed just to try and relax a bit."
Incorporating group into life	Making time for group sessions and home practice	P6/L89 "I was worried about getting the time off (…) But my manager was really good about it.
	Group becoming part of a routine	P1/L25 "one of the other things about the groups, and that's different to individual therapy, is it happens at the same time every week and it becomes part of people's rhythms and routines."
	Planning the right time for home practice	P7/L201 "I: What's helped you to put that learning into place at home? (…)P: I just planned my day what I gonna do. And in advance what I gonna do"
	Strategies to remember home practice	P1/L279. "So actually having that physical prompt for learning. So we give people mp3 players with the recordings on."

	Clinic signalling expectation to prompt home practice	P1/L291. "we talk a lot about the important of what happens between sessions too."
Learning	Learning from other group members	P4/L23. "And to hear about other people's techniques, about what they use to help themselves. It gives me ideas to try."
	Learning to control voices and not fear them	P2/L62. "They're helping you to understand that the voices can't harm you and you can resist what they're saying."
	Understanding the voices	P2/L6 "I know they can't make the voices go but they can make you understand it better. That's what I've been learning so."
Category I. Rewards of engagement		
Progress motivating ongoing engagement	Attributing positive change to the group	P6/L157. "What was the hook that kept you coming back? (…) P: Just knowing that the mindfulness was helping me and making a difference."
	Drawing hope from others coping	P4/L101. "was amazed because people have not heard their voices since they've been doing it and although I'm quite jealous about that it does give me a bit of my hope."
	Group journey	P1/L87. "But I think there's something about patting ourselves on the back and reminding ourselves that we're on a journey of learning that's got legs, that's got momentum, that's moving forward."
	Hoping to inspire others through own coping	P6/L128. "You want to communicate your ideas and hopefully be some kind of role model really, in a way."

	Mindfulness aiding relaxation	P4/L63. “especially when at night when I’m panicking and everything at night-time you can’t just pick up the phone and ring someone at three in the morning and you know to do mindfulness or grounding techniques with holding something even if it’s just for a few minutes it brings it down a little bit to make it a bit more manageable.”
	Pride in group participation	P5/L129. “That’s why I wanted to go to this meeting. I did fight for it and I have done it. Most of it anyway so I’m a bit proud of myself for that.”
	Social approval motivating ongoing engagement	P3/L260. “And we clap for each other when we done something good. So it’s like, you’ve done something really well and people can see that and they’re appreciating that and spurring you on.”
	Thinking positively motivating continued engagement	P4/L207. “trying to recall times were happy and made you feel good rather than trying to recall times that you were troubled and that you need help and that you can’t cope and sometimes I think it’s quite nice to have a break from that. And that’s continued for me to be going I think.”
Improved coping with voices	Finding evidence to question voices	P3/L256. “When Roger was saying, “we need to find evidence that the voices are lying” I really likes when he says that. Because sometimes when the voices tell me something I question them now.”
	Ignoring voices	P8/L166. “Sometimes I get them for a little while and

		then I just say, "I'm not going to listen to you, I'm going to close my eyes""
	Negotiating with the voices	P7/L29. "Or if I want to don't speak, maybe I come back later to the voice and answer the question."
	Noticing progress through comparison with others	P12/ L209. "And the people who were further back than me, I could relate to them in that I had been there and it showed me how much I'd come on."
Universality in the established group	Others sharing one's suffering	P3/L89. "It does work. It's nice because you know that there's somebody there suffering the same problems as you are. I'm not alone."
	Sharing discontent about the group.	P3/L58. "Yea because we do talk afterwards and most of us don't like the meditation."
	Universality inspiring continued engagement	P2/L232. "And I don't feel so alone, knowing that the other people in the group have got similar things to me. I: Yea. So it's quite hopeful. P: Yea it's given me a lot of hope. Yea. I actually look forward to going every week now."
Group cohesiveness	All members' contributions valued.	P3/L249. "It's nice because we all do something and we all contribute to the group."
	Compassion between group members	P4/L168. "there seemed to be quite a caring mode and because obviously being disabled I have noticed a kindness to me, which is something I'm not really used to."
	Understood by other group members	P2/L291. "There's a place called Stepping Stones that does other mental health activities and you can go. It's like a drop-in centre

	Social outlet Catharsis Social approval	really. But I don't feel- I always feel anxious going there but this group, because we all understand each other. I feel part of a group." P2/L175. "I sort of look forward to it. It gets me out of the house. Because I look myself away in doors a lot and it gets me out of my flat and mixing with people." P2/L83. "But when I'm in this group you feel part of the group and because they've all got the same thing, it helps you to talk. Get all your thoughts out that you've bottled up." P3/L251. "sometimes we go a bit earlier and we feel ok to talk among each other and say things what we've done and give each other encouragement."
Category J. Anticipated loss/ planning for maintenance		
Anticipated losses	Group cohesiveness Worrying about going downhill Left with nothing	P3/L374. "it's a very nice group and we all like each other now (…) So then it comes to an end and you go back to your lives again and the new people go and then we're the forgotten ones in some sense." P8/L165. "That's going to be difficult (the group ending) because if I'm not careful, yes I shall get the voices back. At the moment they're sort of half-and-half." P5/L250 "I've been fighting this, most of it myself anyway, since I was little. I mean my teen up until now. It's only recently, two, three years ago I've started getting this help and I don't want to

	Therapeutic effects short-lived	let it go because I'm not ready." P10/ L225. "But it's helpful in the moment. I would want to see evidence that that universality has a long-lasting effect on their voice hearing."
Planning for maintenance (Q with clinicians)	Clinic supporting ongoing learning Resources restricting maintenance planning Desiring ongoing work on voices Carrying forward group's shared knowledge	P1/L56. "So drop-ins and the app are light-touch ways to help people to continue learning after they've left the clinic." P1/L42. "Ideally we would have a meeting with everyone's care-coordinator at the end of therapy, but we can't resource that." P3/L387. "Yea because at the (mental health service) they don't talk to me about voices. I don't think anyone understand it much there. You just go there, like key work and tell them you know, "I'm having voices" but there's no. They don't give anything back or have anything to say, so that's really hard because there's stuff for the other parts I'm dealing with but nothing for my voices, so I'm kind of like really sad that it's going to be ended and then I'll feel like, "there'll be nothing for my voices again, I'll be left on my own again"." P4/L276. "I mean that's no disrespect to my care coordinator but she has very different ideas and I don't want to get confused with what I've been doing and then someone with different ideas because it will just clog up my system."

	Memento of graduation from the group	P4/L315. "I think an app would be a good idea because it would just keep you going and it leaves you with a gift at the end of the group, you've got an app on there, if you need it(…)a validation of what you've been through and that it does actually exist. You're being taken seriously
	Continued contact with the group valued	P3/L367. "if they just had something once a month where you could just go and see everyone again and just say, "I'm doing well, what have you been doing?""
Category K. Responses post-therapy		
Integration	New understanding of voice hearing	P4/T2/L126. "I mean I found the whole experience very positive. It gave me a lot to think about, to try and logically work out in my mind why this was happening."
	Internalised universality	P4/T2/L85. "it sounds really depressing to be thankful that others are going through the same thing as yourself(…)for me it's really important that I've got those two people on my phone."
	Internalised hope	P12/L222. "I: Did you hold on to that at any stage after the group ended?(…)P: I suppose I've still held on to the fact that there are people who suffer with voices but they can really get on with their lives and really deal with them. So yea I guess I've held on to that to some extent. So yea, that's been really positive.
	Connecting with new groups to support learning.	

	Adapting mindfulness and integrating it into life	P4/T2/L185. "There's a group apparently coming up, that uses mindfulness and I do want to be going to that. It's something that I'm hoping I can get involved with because I would like to be around like minded people that use that experience of mindfulness." P4/T2/L193. "with mindfulness you've got to be able to use it without having to look it up in a book each time you use it. It just doesn't work that way. For me I slide into it when I need to."
Loss	Loss of group belonging	P2/T2/L69. "Well the group ended and then I was at a loose end because (…) I felt part of a little group and like I belong somewhere."
	Failed attempts to keep the group	P2/T2/L95. "So when Debbie arranged the meet-up I didn't go, which was a bit of a shame really because it would be good to have someone to sit and have a chat with. But I sort of hide away in doors because I find it easier."
Category L. Leaving room to reconnect with the clinic	Ambivalence about dropout	P9/L157. "Maybe I should have told her to call me back because maybe I would have gone back but I told her not to because- I don't know. You get a bit like that when you get anxious."
	Continued contact after dropout valued	P13/L214. "The only positive thing I took away was that I felt very listened to by the facilitators and they accepted when I said, "I just can't do this". (…) They were very much in contact

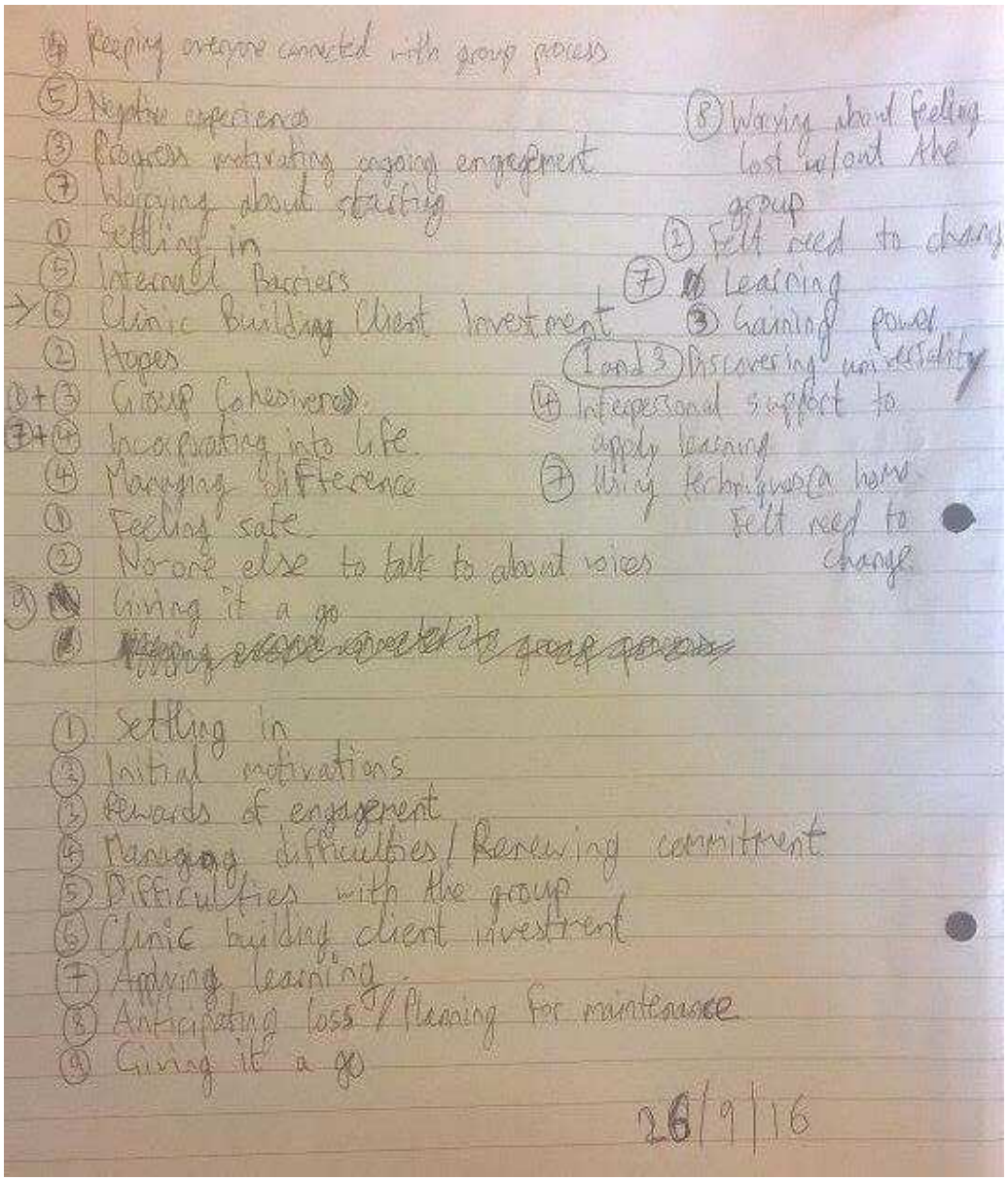
		to see if I was alright and (…) offer me an alternative when it became clear that that wasn't going to work."

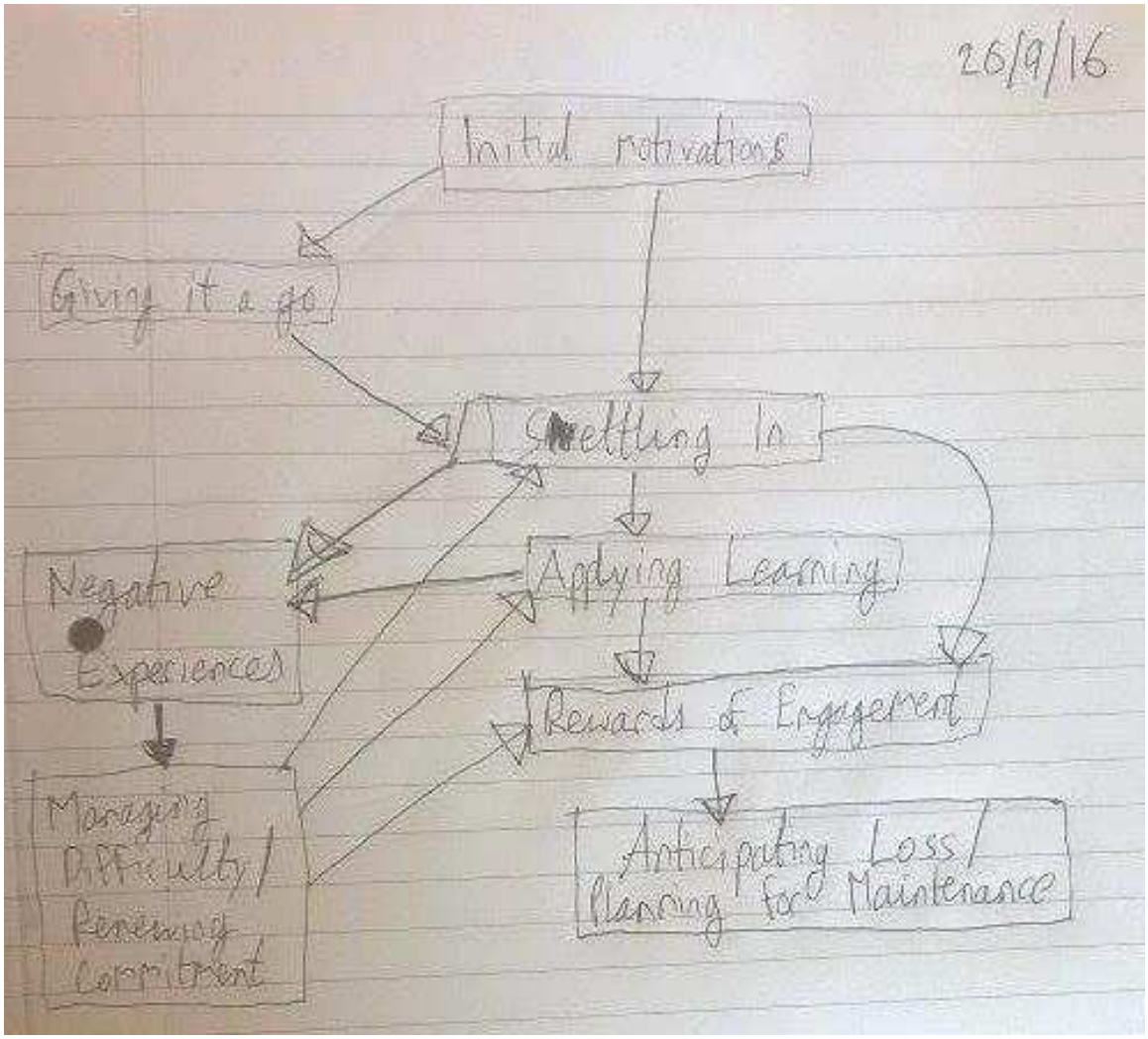
Appendix N. Example coded interview transcript

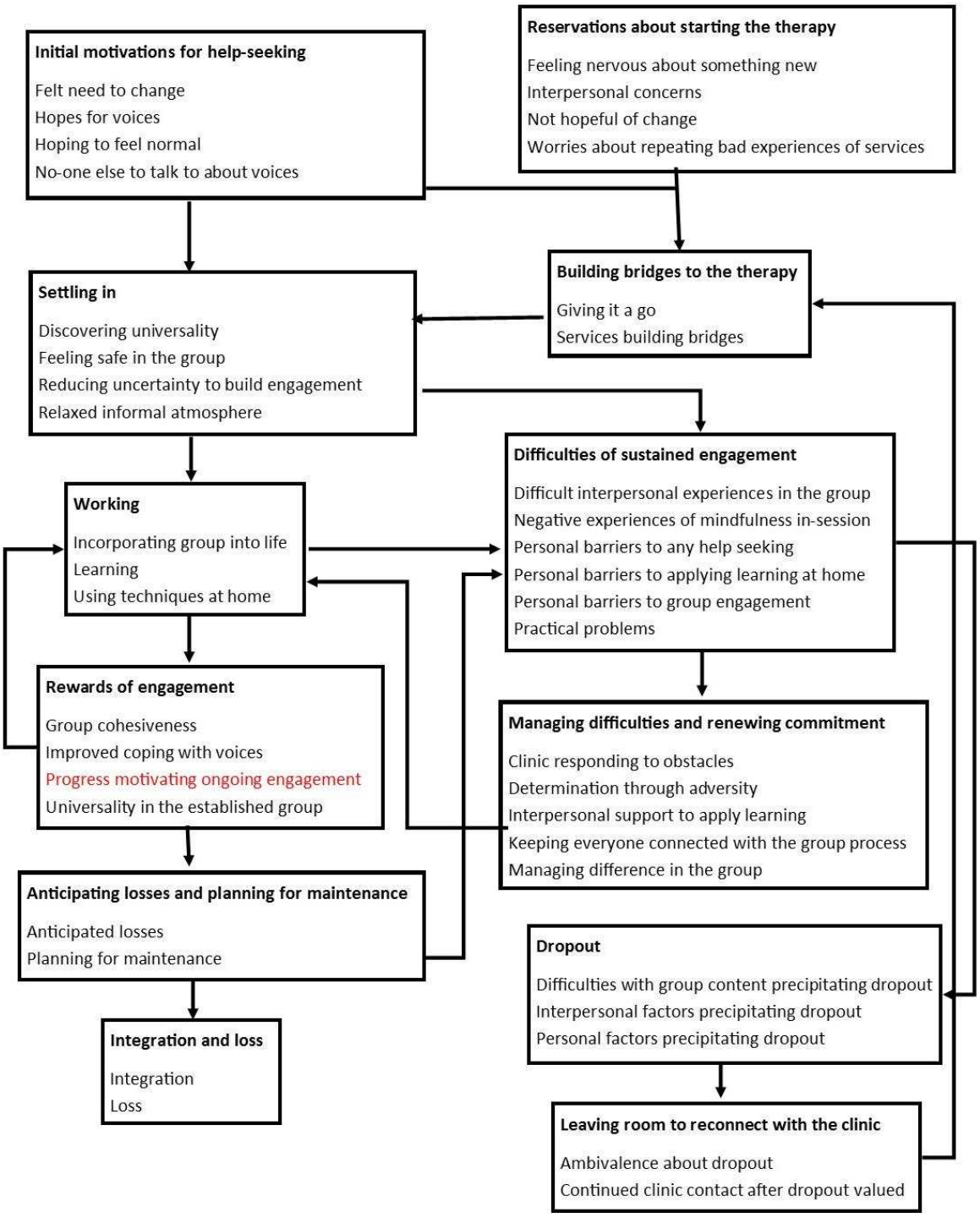
* This has been removed from the electronic copy*

Appendix O. Early model development

This appendix depicts the development of an earlier iteration of the model. My supervisor suggested that this iteration was difficult to follow and gave a false sense of a strict causal sequence. The later iteration was an attempt at a simpler model that was less organised by a sequence of group stages.




26/9/16
Initial motivations
Giving it a go
Settling In
Negative Experiences
Applying Learning
Rewards & Engagement
Managing Difficulty / Renewing Commitment
Anticipating Loss / Planning for Maintenance


Initial motivations for help-seeking
Felt need to change
Hopes for voices
Hoping to feel normal
No-one else to talk to about voices
Reservations about starting the therapy
Feeling nervous about something new
Interpersonal concerns
Not hopeful of change
Worries about repeating bad experiences of services
Building bridges to the therapy
Giving it a go
Services building bridges
Settling in
Discovering universality
Feeling safe in the group
Reducing uncertainty to build engagement
Relaxed informal atmosphere
Working
Incorporating group into life
Learning
Using techniques at home
Difficulties of sustained engagement
Difficult interpersonal experiences in the group
Negative experiences of mindfulness in-session
Personal barriers to any help seeking
Personal barriers to applying learning at home
Personal barriers to group engagement
Practical problems
Rewards of engagement
Group cohesiveness
Improved coping with voices
Progress motivating ongoing engagement
Universality in the established group
Managing difficulties and renewing commitment
Clinic responding to obstacles
Determination through adversity
Interpersonal support to apply learning
Keeping everyone connected with the group process
Managing difference in the group
Anticipating losses and planning for maintenance
Anticipated losses
Planning for maintenance
Integration and loss
Integration
Loss
Dropout
Difficulties with group content precipitating dropout
Interpersonal factors precipitating dropout
Personal factors precipitating dropout
Leaving room to reconnect with the clinic
Ambivalence about dropout
Continued clinic contact after dropout valued

Appendix P. Selected memos.

This appendix exemplifies how my thinking developed through a small selection of memos. The later memos concern developing the properties, dimensions, contexts and actions/ interactions of categories and the links between categories. The earlier memos are generally a record of certain "hunches" developing with regard to the analysis.

14th May 2016. Hope vs. hopefulness.

I have used "hope" in quite different ways between codes. Sometimes hopes are aims or goals. But when I talk about the group inspiring hope, I mean an emotion that people are feeling - hopefulness. Perhaps people start with particular hopes in mind and when they see themselves or others start to achieve some of those they feel that hopefulness. Maybe people arrive at hopefulness simply through acceptance in the group and not feeling alone, regardless of specific goals being met. ********Perhaps this experience of hopefulness is necessary to motivate ongoing engagement after an initial "give it a go" period.********* Maybe in future interviews I can ask why didn't you leave at various points? How did you resolve ambivalence?

13th September 2016. How are relaxing, orientating and group structure related

Maybe group structure supporting orientation is just one way in which group structure facilitates relaxation/ settling in/ feeling at home. e.g. group structure is containing and predictable and so facilitates "settling in".

22nd September 2016. Difference in the group.
I just moved the code "curtailing contributions because of a quiet group" under the sub category "managing difference within the group". This seems to be an example of of someone regulating their behaviour so as not to be too much of an outlier. Presumably the clinic have strategies to manage difference but the clients are also taking personal responsibility for this.

This may end up relating to a larger theme of "establishing safety" or something.

But perhaps between difference and safety is - establishing universality. Universality is a means by which safety is achieved despite difference in the group. Perhaps there any many further mechanisms.

29th September 2016. Giving a go and settling in
Several people talk about "giving it a go" without too many expectations. One person consciously avoids that in order to avoid disappointment. The group in turn expects this kind of initial commitment from participants. This gives way to the "settling in" category where patients reach out for a sense of safety in variouss ways but also "size things up" and look for evidence the process will be helpful or worthwhile in some way.

Edit: 17/11/2016.

"Giving it a go" - has the properties "commitment" and "evaluation". The commitment is on the "short-term/tentative" side of the dimensions and evaluation is "loose/ delayed". This allows "the experience to speak for itself" as James says.

However, this is a dynamic process and expectations are adjusted. How do people adjust their expectations? When do people do so rather than just drop out? The people I spoke to dropped out because they felt unsafe, not because they were pessimistic about change.

18/11/2016

Motivation: Internal vs. External Jim "That they were asked-stroke-encouraged to do the group. That they weren't that motivated to begin with. When somebody's referred and it's not their choice as such." (Mozart) "if they've gone to all this effort then you would go rather than not go."

Benefits and drawbacks to the above? Clusters with "suspending judgement"

17th September 2016. Context and properties of managing difficulties.

One action/interaction is pacing, which is a response to the causal condition of obstacles - people's impairments etc. These are anticipated ahead of the group. Other practical problems might be more like intervening conditions.....so might need to rejig that. (Roger) "we're just taking it forward a little bit. Acknowledging people's cognitive impairments, difficulty focussing because of voices and generally the sense that our client group is not one that's used to being in learning spaces."(Paul) "But this group, we have a break halfway through and that just helps me alone, just having a break halfway through it."

An intervening condition was the obstacles "distressing views from another group member" and the action/interactional sequence that allowed continued investment was (a) a phonecall to gather information on the issues and (b) a change in how the group was facilitated. Debbie gives an example where she told Roger she gets tired and he brings her into conversations to keep her awake. Info gathering + adjustment - needs both parts. What are the different ways info is gathered? (Dexter) "And they had a word with the people who run the group, and now they manage her differently. So when she does go on about things they try to say, "it's ok, you do have your religion and you believe that but not everybody does". And then they try to get her back on to what we were talking about. So that's more helpful." This was under the code responding to individual needs but is also an example of curtailing contributions. Jim described the same process.

Another few actions/ interactions: negotiating with voices (Mozart) drawing determination from a battle to beat voices (Dexter). Is the invitation for that there in what Roger says "I wonder why they don't want you to come?" - Dexter did say that.

The actions/interactions will obviously vary considerably with the causal condtions. Different problems require different sorts of solutions.

One of consequences of the clinic's active involvement in **keeping people connected with the group process** is that it provides evidence to people that they aren't annoyed with them for missing a session and gives them the courage to reconnect with the clinic should they wish to.

Problem solving: Collaborative vs. individual: (Taylor) "One of the facilitators phoned me afterwards, a few days later, and I think I said at that point that I just couldn't cope with coming back and that mindfulness wasn't for me and we talked about it." (Jim) "So we asked her to leave. So that was a clear dropout but one that we instigated." (Dexter) " I know one lady there and we're really good friends and that helps us because we talk outside and we try to give each other encouragement to go to the next group." (Roger) "I think the other patient who was quite eccentric and quite on an island of

their own, I think against the odds, or against expectation, actually stayed with the group and turned up every session, and the group started to look after her and that felt quite cohering."

What would lead to a collaborative problem solving strategy? One thing seems to be capacity: low vs high. (Roger) "I think that's the case and I think the difference is that some people had the sense of, "well I'm able to care for you, I'm maybe not struggling as much as you are""

Clinic involvement: Active vs. passive: (Taylor) The only positive thing I took away was that I felt very listened to by the facilitators and they accepted when I said, "I just can't do this". They accepted that and they didn't just- at no point did I feel like they just thought, "of they just dropped out and that's that, I'm just not going to think about them any more". They were very much in contact to see if I was alright and what I had decided to do and yea, offer me an alternative when it became clear that that wasn't going to work. (Louise) "The guy who was taking drugs, they were even trying to work out could he get the bus fare paid by the clinic and stuff so they did actively tryo to engage him".

It's the clinic's active involvement that makes people feel cared about.

Client engagement: Active vs. passive (Debbie) "By contributing really and hearing other people talk but also being able to say things myself. And that was important that I wasn't going to just blend in with the surroundings and get lost on the way."

Problem-solving: Rigid vs. flexible: (Taylor) "because I then went on to do the relating therapy with Roger on an individual basis. (Dexter) " just kept, I put my music on. I kept doing my distractions, I tried my meditation. What else- I did my headphones, I rang a friend. I just kept on doing different things. Walking around the flat a little bit. I cleaned a bit."

Conviction: Certain vs. ambivalent: (Tracy) "Maybe I should have told her to call me back because maybe I would have gone back but I told her not to because- I don't know." (Taylor) "I just couldn't cope with coming back and that mindfulness wasn't for me and we talked about it but I'd pretty much made my decision".

Anxiety tolerance: Low vs. high: (Debbie) "That's why because the more you miss the harder it is to go back. So the next week was hard. It would have been very easy for me to have not come." (Tracy) I couldn't make the first session so I felt like other people kind of knew each other and I didn't know anyone. "

Determination: low vs. high (Dexter) "Yea, when I went for my coffee. I managed to go but it took me about four hours to get out of the house and go but I got there in the end. So it just takes a lot of energy to keep fighting them. You try to have a shower and they're distracting you in the shower. Or if I'm trying to cook an egg or something and they distract me and I burn the egg and the fire alarm goes off and then the neighbours get annoyed because the alarm's going off – I live in flats. Sometimes it's just easier to think, "fuck it I'll stay in bed"."

19th November 2016. Links between obstacles and managing difficulties.

A very direct example of a relationship between obstacles and managing difficulties. (Paul) "And it can put your mood down and make you feel like not going out and I stay indoors a lot. And when they ring you up and check you're going to the group it reminds me that they still care, so I go."

And another this time universality/ others sharing difficulties: (Paul) "And then he asked how the mindfulness- he asked how that went for everybody and a lady in the group said that her voices were

telling her not to listen and then I thought “well I’m not the only one” and then I said the same “mine interfered a little bit”. I was listening to the mindfulness in the first one and I remember I was listening to bits of it and then losing the concentration and coming back again."

24th November 2016. Properties of rewards of engagement.

There's an overlap between rewards and safety. (James) "There was one week where I didn’t make it was quite nice. I thought “oh they’re probably glad I’m not there” and when I arrived the next week one of the ladies said, “aw we missed you last week I’m glad you’re back” which is really sweet so I felt really nice about that.

I: So that kind of feedback is encouraging.

J: It was just nice because I was thinking, “god they’re probably just bored of me now” <laughs>.

I: So that was a bit reassuring." Also "all contributions valued".

Here's a direct quote that makes the link between evaluating usefulness and driving further investment. From james. "o anything then that once you were attending made you want to keep attending the group? What was the hook that kept you coming back?

J: Thinking that it would be beneficial, thinking that I would learn something that would help me deal with the music or learn to cope with the music better. Just knowing that the mindfulness was helping me and making a difference."

*Interestingly "noticing progress" often dovetails with "finding evidence to dispute the voices claims". So the therapeutic task is one that draws attention to a change process. Dexter " Because we go through it quite a lot in the groups and we write things down. They always have it on the wall. What we did the previous week. And then we always go back to it. So we all know, “we said this the last week” or “the voices are not true because we did go for a coffee or someone went swimming”. We can do that even though we’ve got voices. So we know when we go back we can look on the wall and see the work we’ve done. "

Upon first inspection "attributing positive change to the group" seems like an action/interaction by which rewards of engagement links to continued investment. Whereas some of the other are just straight up rewards.

Given the above, I've now separated out "this journey's got legs" (an in-vivo code from Roger) as it's own sub-category. This sub-catego+ory can be seen to answer the question "how are the rewards of engagement (useful learning, and interpersonal rewards) evaluated as useful, and expected to come about through group participation (therefore driving investment before and after the rewards show themselves).

Three processes: expecting rewards, noticing rewards, linking them to the group.

Change: concrete vs. abstract Interestingly both quotes here come from therapists. They seem to think along this dichotomy. People do describe a variety of interpersonal rewards and noticing self-porgress with particular behavioural goals. There's no indication they regard the former as abstract/ nebulous/ less worthwhile. e.g. (Jim) "So I think what the behavioural experiments do, is give people something very concrete to do. Something that they know they’ve achieved or not achieved.

Tangible barriers or successes. It helps people to focus on goals as I've said so it encourages them to think about change. Gives them that sense of satisfaction, gives them that sense of control over their behaviour. Of which, looking to change your beliefs doesn't I don't think." (Ryan) " So it's, hang on I'm putting my numbers down and I am improving, and I have improved and the voices clinic did help me actually because I'm going out more I'm going along places because I used to have a phobia of going out but I went to (nearby city) next week I'm going on holiday near (nearby town)." (Louise) "P: I'm not sure there was such dramatic concrete changes. I think the changes were perhaps a bit more subtle."

Change: planned vs. spontaneous e.g. (Debbie) "The way that it's planned even the roleplay moments where everyone went, "<gasp>" and didn't want to actually meet Roger's eye so everyone's looking around. And actually I found myself offering, and part of me was thinking, "what are you doing!?""

Change: independant vs. group-based e.g. see above! (Dexter) "So we all know, "we said this the last week" or "the voices are not true because we did go for a coffee"

Noticing change: contemperaneous vs retrospective: e.g. (Ryan) " So it's, hang on I'm putting my numbers down and I am improving, and I have improved and the voices clinic did help me actually because I'm going out more I'm going along places because I used to have a phobia of going out but I went to (nearby city) next week I'm going on holiday near (nearby town)." vs. (Debbie) "The way that it's planned even the roleplay moments where everyone went, "<gasp>" and didn't want to actually meet Roger's eye so everyone's looking around. And actually I found myself offering, and part of me was thinking, "what are you doing!?""

Change: nascent vs. transformational - "all contributions respected" this seems to be a reward open to all, which probably makes the group feel safer. Also think about pride in group participation. However, some people are pleased with transformational changes and are hoping to inspire others. There is room for all of it. Good example of the utility of difference. e.g. "I was in psychodynamic therapy for about three years once or twice a week. And that had a result in itself in a different way but it never really got rid of the music. So this is- this does that for me and it's been immediate." (Debbie) "I was amazed because people have not heard their voices since they've been doing it and although I'm quite jealous about that it does give me a bit of my hope. Maybe I won't get rid of my voices completely but maybe they will tone down. It will be interesting to see." - People can be happy with the former but witnessing the latter is motivating. (Paul) "It's nice because we all do something and we all contribute to the group." (James) "Roger has managed that really well, to celebrate people's successes. Whether they be small or large or whatever."

Change: personal vs. social (e.g. see personal progress and drawing hope from others)

Rewards: hard-won vs immediate. e.g. (Roger) "So we talk about how voices can sometimes sabotage your attempts to get help and then we might wonder for a moment why that is, "maybe voices don't want you to get stronger?" So voices do try and sabotage." (Paul) " But when I'm in this group you feel part of the group and because they've all got the same thing, it helps you to talk. Get all your thoughts out that you've bottled up."

Rewards: fleeting vs. lasting "Responses to ending partly answers the "how" of this dimension. e.g. (Paul, T2) "So they have a big impact on you in day to day life. Does it feel like the group has had any ongoing benefit given that all this stuff's going on?

P: Yea, well the mindfulness thing I learnt, which was good. And they taught us that the voices can't control you. The group made me understand a bit more about how the voices affect you. How to react to them. How to get through the day really. " (Jim) "The fact that you have the same experience as me is

comforting in the moment but that's all well and good. When I go home I'm still hearing voices, I'm not going to think, "oh Ciaran also hears voices, isn't that really comforting". I hear voices, I'm still distressed by them. So I think in the moment it's nice, it's comforting but I don't think it has a fundamental, long-lasting effect on someone's distress."

Change: thinking vs. behaving e.g. (Debbie T2) "Yea I mean I found the whole experience very positive. It gave me a lot to think about, to try and logically work out in my mind why this was happening." + See above for behaving.

Effectiveness: reliable vs. cotingent (on what?) (Debbie) "Mostly (mindfulness works). I'm not going to lie, there's times that life gets in the way and at night is a time when I'm panicking."

Lots to gain (Paul) "Not really. After I done the first few sessions I decided- because I don't have a lot to do in the week and it's something- in a strange way I sort of look forward to it. It gets me out of the house. Because I look myself away in doors a lot and it gets me out of my flat and mixing with people."

Appendix Q. Number of Instances and Sources of Codes. September 2016.

This table was exported from Nvivo. This shows the number of occurrences of each code in the data ("coding references") and the number of interviews these were spread across ("sources coded"). This table was exported in September 2016 at an earlier stage of data analysis.

Name	Number Of Sources Coded	Number Of Coding References	Created On	Modified On
Accommodating internal barriers to engagement in-session	1	1	7/22/2016 1:09:03 PM	7/22/2016 1:09:03 PM
Achieving goals	1	1	5/14/2016 1:18:29 PM	5/15/2016 3:12:59 PM
Adjusting expectations - voices won't go	2	5	5/12/2016 11:38:09 AM	7/22/2016 12:44:08 PM
Agitation interfering with home practice	1	2	5/12/2016 4:28:36 PM	5/12/2016 4:39:19 PM
Applying techniques independantly	1	1	7/22/2016 12:17:26 PM	7/22/2016 12:17:26 PM
Attributing positive change to the group	1	1	5/14/2016 12:18:44 PM	5/15/2016 3:12:59 PM
Bad advice from group members worsening struggle with voices	1	1	5/14/2016 3:36:41 PM	5/15/2016 3:12:59 PM
Battling to achieve goals	1	1	5/15/2016 3:53:25 PM	5/15/2016 3:53:25 PM
Break helping concentration	1	1	5/14/2016 11:31:14 AM	5/15/2016 3:12:59 PM
Bringing voices into the open	2	3	5/12/2016 3:39:46 PM	7/22/2016 3:12:13 PM
Caring for less able group members	1	1	7/22/2016 2:28:20 PM	7/22/2016 2:28:20 PM
Catharsis	1	1	5/12/2016 12:14:54 PM	5/15/2016 3:12:59 PM
Changing group dynamics	1	1	7/22/2016 2:26:38 PM	7/22/2016 2:26:38 PM
Clinic expectation to give it a go	1	2	7/22/2016 2:44:44 PM	7/22/2016 2:45:53 PM

Clinic learning from problems	1	2	7/24/2016 10:43:32 AM	7/24/2016 10:45:53 AM
Clinic not expecting full attendance	1	1	7/24/2016 11:17:22 AM	7/24/2016 11:17:42 AM
Clinic reponsilbity to support learning outside sessions	1	1	7/22/2016 12:42:25 PM	7/22/2016 12:42:25 PM
Clinic signalling expectations to prompt homework	1	5	7/24/2016 10:49:52 AM	7/24/2016 11:14:38 AM
Cliquey patient building bridges	1	1	7/22/2016 2:19:39 PM	7/22/2016 2:19:39 PM
Community setting encouraging more activity	1	1	7/22/2016 2:31:05 PM	7/22/2016 2:31:05 PM
Comparing with previous mental health groups	2	2	5/14/2016 11:28:35 AM	7/10/2016 12:52:00 PM
Considering escaping the room	1	1	5/15/2016 3:11:00 PM	5/15/2016 3:12:59 PM
Containment	1	1	7/22/2016 12:25:12 PM	7/22/2016 12:25:12 PM
Continued attendance bringing tacit contract to engage	1	2	7/22/2016 2:08:48 PM	7/22/2016 2:09:50 PM
Continuity between levels	1	1	7/24/2016 11:28:18 AM	7/24/2016 11:28:18 AM
Coping alone with voices	1	1	5/12/2016 12:11:31 PM	5/15/2016 3:12:59 PM
Curtailing contributions because of quiet group	1	2	7/10/2016 12:42:12 PM	7/10/2016 12:49:09 PM
Deshaming voice hearing	1	1	5/12/2016 3:40:11 PM	5/15/2016 3:12:59 PM
Desiring feedback on progress	1	1	5/14/2016 1:20:23 PM	5/15/2016 3:12:59 PM

Desiring ongoing work on voices	2	4	4/7/2016 4:34:51 PM	7/17/2016 12:09:13 PM
Determined to maximise engagement	1	1	5/12/2016 3:57:42 PM	5/15/2016 3:12:59 PM
Determined to see group through	1	1	5/14/2016 1:15:36 PM	5/15/2016 3:12:59 PM
Discovering group boundaries	1	1	5/12/2016 11:43:44 AM	5/14/2016 12:45:08 PM
Discussing group with pre-existing group contact	1	1	5/14/2016 1:27:00 PM	5/15/2016 3:12:59 PM
Distracting from voices	1	1	5/12/2016 4:29:31 PM	5/12/2016 4:29:31 PM
Drawing hope from others coping	3	5	5/12/2016 4:33:19 PM	7/24/2016 10:56:35 AM
Drawing on learning from level one	1	2	7/24/2016 11:28:02 AM	7/24/2016 11:29:12 AM
Drowning out voices with music	1	1	5/14/2016 11:26:33 AM	5/15/2016 3:12:59 PM
Effort being honoured by the group not minimised	1	1	5/15/2016 3:43:14 PM	5/15/2016 3:43:45 PM
Encouraging pride in progress	1	1	7/22/2016 1:00:24 PM	7/22/2016 1:00:24 PM
Engaging enough to make a difference	1	2	7/24/2016 11:15:57 AM	7/24/2016 11:21:08 AM
Enjoying the group	1	1	5/14/2016 12:05:41 PM	5/15/2016 3:12:59 PM
Establishing safety of group members	1	1	7/22/2016 3:04:48 PM	7/22/2016 3:04:48 PM
Expecting group to be like previous groups	1	2	5/14/2016 11:31:44 AM	5/15/2016 3:12:59 PM
Facilitators managing their own anxiety	1	1	7/22/2016 3:06:09 PM	7/22/2016 3:06:09 PM

Facilitators using language to build universality	1	1	7/22/2016 2:04:58 PM	7/22/2016 2:04:58 PM
Feeling abandoned by mental health services	2	3	5/14/2016 12:14:11 PM	7/10/2016 12:52:23 PM
Feeling different	1	2	5/14/2016 1:28:22 PM	7/10/2016 12:49:29 PM
Feeling different because of culture	1	2	5/14/2016 1:37:23 PM	7/10/2016 12:49:54 PM
Feeling different because of diagnosis	1	2	5/14/2016 1:44:30 PM	5/15/2016 3:12:59 PM
Feeling different because of race	1	1	5/14/2016 1:38:35 PM	5/14/2016 1:38:35 PM
Feeling different because of talkativeness	1	1	7/10/2016 12:41:24 PM	7/10/2016 12:49:41 PM
Feeling held in mind by clinic phonecalls	1	1	7/22/2016 3:01:34 PM	7/22/2016 3:01:34 PM
Feeling like a passive pupil in other groups	1	2	5/14/2016 11:30:17 AM	5/15/2016 3:12:59 PM
Feeling needed by the group	1	1	5/14/2016 12:11:16 PM	5/15/2016 3:12:59 PM
Feeling nervous about new setting	1	2	4/7/2016 5:06:06 PM	5/14/2016 12:45:08 PM
Feeling nervous about something new	2	3	4/7/2016 5:04:55 PM	5/14/2016 12:45:08 PM
Feeling not understood by other group members	1	1	5/14/2016 1:52:26 PM	5/15/2016 3:12:59 PM
Feeling outside group during mindfulness practice	1	1	5/14/2016 1:10:53 PM	5/14/2016 1:10:53 PM
Feeling privilege or scarcity of resource	2	2	4/7/2016 4:41:49 PM	5/14/2016 12:45:08 PM

Feeling relaxed in-session by mindfulness	1	1	4/7/2016 5:13:41 PM	5/14/2016 12:45:08 PM
Feeling safe in the group	1	1	5/15/2016 3:39:33 PM	5/15/2016 3:39:33 PM
Feeling safe with facilitators being caring	1	2	5/15/2016 3:15:28 PM	5/15/2016 3:17:16 PM
Feeling safer to meditate at home	1	1	5/15/2016 3:31:37 PM	5/15/2016 3:31:37 PM
Feeling unable to give negative feedback on mindfulness practice	1	2	5/14/2016 1:24:15 PM	5/15/2016 3:12:59 PM
Feeling understood by the group	1	1	5/14/2016 12:10:22 PM	5/15/2016 3:12:59 PM
Feeling unsafe because of voices	1	2	5/12/2016 3:49:11 PM	5/15/2016 3:12:59 PM
Feeling unsafe meditating in front of strangers	1	2	5/15/2016 3:10:35 PM	5/15/2016 3:13:33 PM
Felt need to change enhancing engagement	1	1	5/14/2016 11:41:38 AM	7/10/2016 12:12:12 PM
Finding benefit from mindfulness	1	1	4/14/2016 1:51:18 PM	5/14/2016 12:45:08 PM
Finding right place for mindfulness practice	1	1	4/14/2016 1:50:50 PM	5/14/2016 12:45:08 PM
Finding time for practice	1	1	4/14/2016 1:52:56 PM	4/14/2016 1:52:56 PM
Finding universality	1	2	5/12/2016 12:04:48 PM	5/15/2016 3:12:59 PM
Fitting group into life	1	1	5/12/2016 10:54:43 AM	7/24/2016 11:09:14 AM
Flexible employer facilitating engagement	1	1	4/7/2016 5:09:35 PM	4/14/2016 1:49:59 PM
Flip chart creating sense of a journey	1	1	7/22/2016 12:57:02 PM	7/22/2016 12:57:02 PM

Flowing with clinic pathway	1	1	5/14/2016 12:58:15 PM	7/10/2016 12:05:10 PM
Flowing with the clinic levels	3	3	4/7/2016 4:40:12 PM	7/17/2016 12:14:55 PM
Forgetting practice	1	1	4/14/2016 1:52:37 PM	5/14/2016 12:45:08 PM
Gaining autonomy over behaviour	3	6	4/7/2016 4:56:04 PM	5/15/2016 3:52:51 PM
Gaining power over voices	0	0	5/12/2016 11:06:26 AM	5/14/2016 12:45:08 PM
Giving it a go	3	7	5/12/2016 11:39:38 AM	7/22/2016 12:09:31 PM
Good experience at level one	1	1	7/17/2016 11:34:49 AM	7/17/2016 11:34:49 AM
Greater loss following group therapy	1	1	7/22/2016 12:26:58 PM	7/22/2016 1:02:22 PM
Group approval motivating achieving goals outside sessions	1	1	5/15/2016 3:42:32 PM	5/15/2016 3:42:32 PM
Group becoming part of routine	3	3	5/14/2016 11:49:05 AM	7/22/2016 12:21:15 PM
Group clashing with other commitments	1	3	4/7/2016 5:07:47 PM	4/14/2016 1:49:59 PM
Group cohering over time	1	1	7/22/2016 2:18:59 PM	7/22/2016 2:18:59 PM
Group cohesiveness	2	5	5/12/2016 12:13:05 PM	7/17/2016 12:04:02 PM
Group diluting therapy	1	2	5/14/2016 1:56:31 PM	7/17/2016 11:37:15 AM
Group facilitating social learning	1	2	7/24/2016 10:59:27 AM	7/24/2016 11:00:30 AM

Group feeling relaxed and informal	1	1	5/14/2016 11:28:58 AM	5/15/2016 3:12:59 PM
Group format acting as a barrier to engagement	1	1	7/22/2016 12:14:25 PM	7/22/2016 12:14:25 PM
Group format alllowing universality	1	1	7/22/2016 2:51:57 PM	7/22/2016 2:51:57 PM
Group inspiring hope	1	1	5/14/2016 12:15:22 PM	5/15/2016 3:12:59 PM
Group interaction driving isolation	1	1	5/14/2016 3:39:54 PM	5/15/2016 3:12:59 PM
Group members encouraging and praising each other	1	1	5/15/2016 3:40:52 PM	5/15/2016 3:40:52 PM
Group members supporting each other outside the group	1	1	5/14/2016 1:41:24 PM	5/15/2016 3:12:59 PM
Group norm - responsibility to speak	3	5	4/14/2016 1:21:04 PM	7/22/2016 2:06:12 PM
Group not returning to hope and worries	1	1	7/22/2016 12:48:58 PM	7/22/2016 12:48:58 PM
Group outlier	1	1	7/22/2016 2:18:33 PM	7/22/2016 2:18:33 PM
Group outliers dropping out	1	1	7/22/2016 2:52:33 PM	7/22/2016 2:52:33 PM
Group rules explicating terms of engagement	1	1	7/22/2016 2:06:59 PM	7/22/2016 2:06:59 PM
Group structure facilitating relaxing	1	2	4/14/2016 1:24:30 PM	4/14/2016 1:41:23 PM
Group structure helping orientation	2	2	4/7/2016 5:12:15 PM	5/12/2016 3:49:48 PM
Group triggering voices	1	1	7/24/2016 11:24:24 AM	7/24/2016 11:24:24 AM
Health problems a barrrier to engagement	1	1	7/24/2016 11:08:12 AM	7/24/2016 11:08:12 AM
Hearing everyone's voice to facilitate settling in	1	1	7/22/2016 12:50:20 PM	7/22/2016 12:50:20 PM

Hearing everyone's voice to facilitate settling in	1	1	7/22/2016 12:51:19 PM	7/22/2016 12:50:20 PM
High clinic expectations precipitating disengagement	1	1	7/24/2016 11:01:53 AM	7/24/2016 11:01:53 AM
Highlighting victories over voices	1	1	7/22/2016 3:20:33 PM	7/22/2016 3:20:33 PM
Holding absent group members in mind	1	1	7/22/2016 3:03:50 PM	7/22/2016 3:03:50 PM
Homework not engaged with	1	1	7/24/2016 10:49:16 AM	7/24/2016 10:49:16 AM
Hopes	0	0	5/12/2016 11:36:37 AM	5/14/2016 12:45:08 PM
Hoping to control voices	1	5	4/7/2016 4:51:12 PM	4/7/2016 4:57:59 PM
Hoping to expand horizons	1	1	5/12/2016 4:04:11 PM	5/12/2016 4:04:11 PM
Hoping to feel normal	1	1	4/7/2016 4:54:38 PM	5/12/2016 11:27:50 AM
Hoping to get rid of voices	2	3	5/12/2016 11:37:00 AM	7/22/2016 12:44:02 PM
Hoping to inspire others through own coping	2	2	5/15/2016 3:47:20 PM	7/24/2016 10:56:33 AM
Hoping to learn techniques	1	2	4/7/2016 4:50:49 PM	4/7/2016 4:53:54 PM
Hoping to share experiences	1	2	4/7/2016 4:51:47 PM	4/7/2016 4:58:53 PM
Hoping to understand voices	1	2	5/12/2016 11:36:31 AM	5/12/2016 4:03:52 PM
Hospitality	1	1	7/22/2016 2:33:14 PM	7/22/2016 2:33:14 PM
Identification with diagnosis setting up negative expectation of mindfulness	1	1	5/14/2016 1:09:56 PM	5/15/2016 3:12:59 PM

Identifying with another based on diagnosis	2	5	5/14/2016 1:44:42 PM	7/24/2016 11:30:27 AM
Immediate cohesiveness	1	2	7/22/2016 2:11:24 PM	7/22/2016 2:23:21 PM
Inclusiveness	2	2	5/12/2016 2:56:42 PM	7/22/2016 1:03:51 PM
Instability in people's lives a barrier to home practice	1	1	7/24/2016 11:07:29 AM	7/24/2016 11:07:29 AM
Internal barriers to engagement	0	0	7/22/2016 1:10:12 PM	7/22/2016 1:10:12 PM
Internal factors interfering with home practice	0	0	5/12/2016 4:39:51 PM	5/15/2016 3:12:59 PM
Internalising cognitive model	1	2	5/15/2016 3:33:36 PM	5/15/2016 3:37:53 PM
Interpersonal sensitivity	1	2	7/22/2016 2:46:28 PM	7/22/2016 2:50:20 PM
Jumping straight in before getting to know each other problematic	1	1	5/14/2016 3:55:02 PM	5/15/2016 3:08:13 PM
Keeping up with group's shared knowledge.	1	1	5/12/2016 4:16:30 PM	5/15/2016 3:12:59 PM
Lack of opportunities to talk about voice hearing	1	1	7/24/2016 11:29:47 AM	7/24/2016 11:29:47 AM
Lacking activity	1	3	5/12/2016 11:50:47 AM	5/15/2016 3:12:59 PM
Learning	1	2	4/14/2016 1:43:25 PM	5/14/2016 12:45:08 PM
Learning enough from level one	1	1	7/22/2016 12:16:25 PM	7/22/2016 12:16:25 PM
Learning from other group members	3	6	4/7/2016 4:59:34 PM	5/14/2016 1:21:43 PM
Learning mindfulness	1	1	4/14/2016 1:49:49 PM	4/14/2016 1:49:49 PM
Learning not to fear voices	1	1	5/12/2016 11:59:35 AM	5/12/2016 11:59:35 AM

Learning techniques	1	2	4/14/2016 1:42:56 PM	4/14/2016 1:47:01 PM
Learning to control voices	1	1	4/14/2016 1:47:43 PM	4/14/2016 1:47:34 PM
Losing cohesiveness	1	1	7/22/2016 12:18:22 PM	7/22/2016 12:18:22 PM
Losing learning without practice	1	1	7/22/2016 12:43:15 PM	7/22/2016 12:43:15 PM
Maintaining progress through support from other services	2	3	7/17/2016 11:41:35 AM	7/22/2016 12:41:11 PM
Managing difference in the group	1	1	5/14/2016 3:43:42 PM	5/15/2016 3:12:59 PM
Meditating with others requiring trust	1	1	5/15/2016 3:12:03 PM	5/15/2016 3:12:59 PM
Members dropping out because of mindfulness	2	3	5/14/2016 1:14:55 PM	7/22/2016 3:18:14 PM
Mental health groups being hard work	1	1	5/14/2016 11:39:49 AM	5/15/2016 3:12:59 PM
Mindfulness and feedback wasting too much time	1	1	5/14/2016 1:12:43 PM	5/14/2016 1:13:34 PM
Mindfulness and other techniques facilitating relaxing	2	3	4/7/2016 5:15:30 PM	5/12/2016 3:32:27 PM
Mindfulness recordings supporting ongoing practice	1	1	5/14/2016 12:05:16 PM	5/15/2016 3:12:59 PM
Mindfulness triggering voice hearing	1	1	7/22/2016 3:18:28 PM	7/22/2016 3:18:58 PM
Momentum	1	1	7/22/2016 12:59:46 PM	7/22/2016 12:59:46 PM
Mood interfering with engagement	1	1	5/12/2016 11:53:35 AM	5/15/2016 3:12:59 PM
Motivated by positive experience at level one	2	5	4/7/2016 4:33:30 PM	7/17/2016 12:15:05 PM

MP3 player physically prompting practice	1	1	7/24/2016 10:42:15 AM	7/24/2016 10:44:40 AM
Nature of voices	1	1	5/12/2016 3:04:25 PM	5/15/2016 3:12:59 PM
Needing an ongoing group	1	1	5/14/2016 12:09:38 PM	5/15/2016 3:12:59 PM
Needing to change	1	1	5/12/2016 3:58:26 PM	5/15/2016 3:12:59 PM
Negative expectations of group therapy	3	3	5/14/2016 12:25:15 PM	7/17/2016 12:16:56 PM
Negative experience of mindfulness in-session	1	1	5/14/2016 1:08:19 PM	5/15/2016 3:12:59 PM
Negotiating with voices	1	1	4/7/2016 4:56:49 PM	4/7/2016 4:56:49 PM
NHS premises encouraging passive patient role	1	2	7/22/2016 2:29:27 PM	7/22/2016 2:32:47 PM
Not building expectations	2	3	4/7/2016 4:49:30 PM	7/10/2016 12:55:12 PM
Opening up once feeling more relaxed	1	1	5/12/2016 2:57:31 PM	5/12/2016 2:57:31 PM
Orientating to group norms	1	1	4/14/2016 1:19:30 PM	5/12/2016 11:23:06 AM
Orientating to group's shared knowledge	2	2	4/7/2016 5:11:34 PM	5/12/2016 4:08:46 PM
Orientation sizing up	3	4	4/14/2016 1:11:06 PM	7/22/2016 2:07:36 PM
Owning own coping strategies	1	1	5/14/2016 11:22:27 AM	5/15/2016 3:12:59 PM
Pacing	1	2	7/22/2016 1:07:38 PM	7/24/2016 11:04:09 AM
Pairing	2	3	5/14/2016 1:39:36 PM	7/22/2016 2:12:11 PM
Participating despite not valuing a group activity	1	1	5/14/2016 1:14:33 PM	5/15/2016 3:12:59 PM

Permission to leave the room	2	3	5/15/2016 3:11:39 PM	5/15/2016 3:16:26 PM
Personal search for coping strategies	1	1	5/14/2016 12:15:43 PM	5/15/2016 3:12:59 PM
Phone calls from clinic assistants facilitating engagement	2	2	5/14/2016 3:41:02 PM	7/24/2016 11:32:37 AM
Phone calls showing the clinic cares and facilitating engagement	1	3	5/12/2016 11:45:27 AM	5/14/2016 12:45:08 PM
Phonecalls addressing practical problems	1	1	7/22/2016 3:02:49 PM	7/22/2016 3:02:49 PM
Physical enviornment influencing group behaviour	1	2	7/22/2016 2:25:36 PM	7/22/2016 2:32:35 PM
Physical materials prompting practice	1	2	7/24/2016 10:50:43 AM	7/24/2016 10:55:34 AM
Planning home practice	1	2	4/14/2016 1:45:42 PM	5/12/2016 11:11:01 AM
Planning to kill one's self when the group ends	1	1	7/17/2016 11:50:43 AM	7/17/2016 11:50:43 AM
Poor concentration interfering with coping strategies	1	1	5/14/2016 11:23:33 AM	5/14/2016 11:25:40 AM
Poor concentration interfering with group engagement	2	2	5/14/2016 11:40:31 AM	7/22/2016 1:13:44 PM
Positive change motivating ongoing engagement	1	1	5/14/2016 12:21:21 PM	5/15/2016 3:12:59 PM
Praising effort to make it to sessions	1	2	7/22/2016 1:48:21 PM	7/22/2016 3:11:33 PM
Pre-existing relationships ameliorating facilitator anxiety	1	1	7/22/2016 1:44:05 PM	7/22/2016 1:45:46 PM
Preferring particular aspects of group	1	2	5/14/2016 1:08:59 PM	5/15/2016 3:12:59 PM
Preferring practical tasks	1	1	5/14/2016 1:20:06 PM	5/15/2016 3:12:59 PM

Preferring privacy of individual work	1	1	5/14/2016 1:02:48 PM	5/14/2016 1:02:48 PM
Prioritising own needs over voice's	1	1	4/7/2016 4:57:17 PM	5/12/2016 11:11:01 AM
Prompting practice	1	1	7/22/2016 12:34:22 PM	7/22/2016 12:34:22 PM
Prompts from facilitators making it safe to speak	2	2	7/10/2016 12:43:36 PM	7/22/2016 12:52:12 PM
Questioning the truthfulness of what voices say	1	2	5/15/2016 3:32:42 PM	5/15/2016 3:37:27 PM
Questioning voices motives	1	2	7/22/2016 3:12:55 PM	7/24/2016 11:25:07 AM
Reaching out despite difference	1	1	7/22/2016 2:22:50 PM	7/22/2016 2:22:50 PM
Reaching out to a group outlier building cohesiveness	1	1	7/22/2016 2:20:29 PM	7/22/2016 2:21:36 PM
Reducing uncertainties facilitating engagement	1	1	7/22/2016 3:07:31 PM	7/22/2016 3:07:31 PM
Referring back to level one therapy	1	2	7/24/2016 11:24:07 AM	7/24/2016 11:31:48 AM
Reflecting on voice hearing in-session	1	1	7/22/2016 3:17:23 PM	7/22/2016 3:17:23 PM
Reluctance to speak	2	2	5/12/2016 2:56:22 PM	5/15/2016 3:12:59 PM
Relying on family support	1	1	5/12/2016 3:48:41 PM	5/15/2016 3:12:59 PM
Respecting personal coping strategies	1	1	5/14/2016 11:22:07 AM	5/15/2016 3:12:59 PM
Responding to individual needs	3	4	4/14/2016 1:11:46 PM	5/14/2016 3:43:05 PM
Right frame of mind to use techniques	1	2	5/12/2016 4:22:40 PM	5/15/2016 3:12:59 PM
Seeking universality	1	2	4/7/2016 4:32:47 PM	5/14/2016 12:45:08 PM

Selling the group	1	2	7/22/2016 12:09:07 PM	7/22/2016 2:50:47 PM
Service resources restricting support	1	3	7/22/2016 12:31:38 PM	7/22/2016 3:05:18 PM
Services not listening or caring	1	1	4/7/2016 5:17:51 PM	5/14/2016 12:45:08 PM
Settling in	2	3	4/14/2016 1:22:46 PM	7/22/2016 1:46:44 PM
Settling in before talking about voices	1	1	7/22/2016 1:47:00 PM	7/22/2016 1:47:00 PM
Sitting back at first	2	4	4/14/2016 1:13:59 PM	5/12/2016 3:16:06 PM
Small group size facilitating engagement	2	4	4/14/2016 1:42:28 PM	5/14/2016 12:45:08 PM
Socialising	3	6	4/7/2016 4:31:24 PM	7/17/2016 12:04:51 PM
Space to move	1	1	7/22/2016 2:33:25 PM	7/22/2016 2:33:25 PM
Staying in touch	1	1	7/22/2016 12:25:58 PM	7/22/2016 12:25:58 PM
Struggling to resist voices' instructions	1	1	5/14/2016 3:27:52 PM	5/15/2016 3:12:59 PM
Struggling with endings	1	2	7/17/2016 11:39:47 AM	7/17/2016 12:11:17 PM
Supplanting ineffective coping strategies for voices	1	1	5/12/2016 4:20:19 PM	5/12/2016 4:20:19 PM
Support from other services enabling achievements at home	1	1	5/15/2016 3:49:35 PM	5/15/2016 3:49:35 PM
Tacit contract contradicting explicit contract	1	1	7/22/2016 2:09:18 PM	7/22/2016 2:09:18 PM
Technical problems	1	1	7/24/2016 10:43:50 AM	7/24/2016 10:43:50 AM

Tiredness interfering with home practice	1	1	5/12/2016 10:41:23 AM	5/12/2016 4:32:25 PM
Trial and error with techniques	2	4	5/12/2016 4:21:19 PM	5/15/2016 3:54:29 PM
Understanding self	1	1	4/14/2016 1:45:21 PM	5/14/2016 12:45:08 PM
Understanding voices	2	7	4/14/2016 1:45:12 PM	5/14/2016 11:44:59 AM
Unhelpful advice from other group members stopping attendance	1	1	5/14/2016 3:26:24 PM	5/15/2016 3:12:59 PM
Universalising worries about being in a group	1	1	7/22/2016 1:50:03 PM	7/22/2016 1:50:19 PM
Universality	2	3	5/14/2016 12:23:18 PM	5/15/2016 3:12:59 PM
Universality dispelling fears of being judged	1	1	7/22/2016 2:47:18 PM	7/22/2016 2:47:18 PM
Universality facilitating cohesiveness	1	1	5/12/2016 3:05:59 PM	5/12/2016 3:15:13 PM
Universality facilitating opening up	1	6	5/12/2016 12:14:04 PM	5/12/2016 3:42:41 PM
Universality motivating ongoing engagement	2	2	5/14/2016 12:24:09 PM	5/15/2016 3:12:59 PM
Using A3 wall sheets to track progress	2	2	5/15/2016 3:35:31 PM	7/22/2016 12:55:46 PM
Using distraction to endure mindfulness practice	1	1	5/15/2016 3:12:54 PM	5/15/2016 3:12:59 PM
Using mindfulness to relax at home	1	2	5/12/2016 4:19:22 PM	5/12/2016 4:23:00 PM
Using mp3 player	2	2	5/12/2016 4:18:46 PM	5/15/2016 3:30:45 PM
Using techniqes from various sources	1	1	5/15/2016 3:55:11 PM	5/15/2016 3:55:11 PM
Using techniques at home	0	0	5/12/2016 4:21:30 PM	5/15/2016 3:12:59 PM

Valuing advice from members who have experience voices longest	1	2	5/12/2016 4:30:31 PM	5/12/2016 4:32:57 PM
Viewing self as changing through enacting new behaviours	1	1	7/24/2016 10:55:19 AM	7/24/2016 10:55:19 AM
Voices causing isolation	2	3	5/12/2016 4:03:30 PM	5/15/2016 3:52:02 PM
Voices criticising	1	1	5/15/2016 3:51:26 PM	5/15/2016 3:51:26 PM
Voices distracting from daily living	1	1	5/15/2016 3:52:17 PM	5/15/2016 3:52:17 PM
Voices driving self-harm	1	1	5/14/2016 12:18:17 PM	5/15/2016 3:12:59 PM
Voices instructing violence	1	1	5/14/2016 3:36:53 PM	5/15/2016 3:12:59 PM
Voices interfering with engagement	3	7	5/12/2016 11:51:58 AM	7/22/2016 1:13:29 PM
Voices interfering with home practice	2	2	5/12/2016 10:41:36 AM	5/15/2016 3:51:06 PM
Voices worse at night	1	3	5/12/2016 12:12:00 PM	5/15/2016 3:12:59 PM
Voices worse at weekend	1	1	5/12/2016 11:49:23 AM	5/15/2016 3:12:59 PM
Vulnerability eliciting compassion in the group	1	1	7/22/2016 2:49:55 PM	7/22/2016 2:49:55 PM
Wanting further engagement with the clinic	3	5	5/12/2016 10:36:18 AM	7/22/2016 12:26:31 PM
Wanting more warning before engaging in exercises	1	1	5/15/2016 3:09:40 PM	5/15/2016 3:09:40 PM
Wanting something new	2	2	4/7/2016 4:30:36 PM	5/14/2016 12:45:08 PM
Wanting to continuously check in with the group	1	1	7/17/2016 11:53:18 AM	7/17/2016 11:53:18 AM

Wishing to make most of time in grou	1	1	5/14/2016 1:58:25 PM	5/14/2016 1:59:42 PM
Worries preditable	1	1	7/22/2016 12:48:11 PM	7/22/2016 12:48:11 PM
Worrying about being different	2	5	4/14/2016 1:56:11 PM	5/12/2016 3:02:20 PM
Worrying about being forgotten by the clinic	1	1	7/17/2016 12:05:54 PM	7/17/2016 12:05:54 PM
Worrying about being in a group	3	6	4/7/2016 5:02:11 PM	7/22/2016 1:30:34 PM
Worrying about being judged	2	3	5/12/2016 12:05:18 PM	7/22/2016 12:13:37 PM
Worrying about being left with nothing	2	3	5/12/2016 10:36:59 AM	7/17/2016 12:08:08 PM
Worrying about feeling lost without the group	1	2	5/14/2016 11:48:45 AM	7/10/2016 12:19:28 PM
Worrying about going backwards when the group ends	1	1	7/17/2016 11:38:40 AM	7/17/2016 11:38:40 AM
Worrying about repeating bad experiences of services	1	1	4/7/2016 5:17:22 PM	5/14/2016 12:45:08 PM
Worrying about seeming crazy	1	2	4/7/2016 5:01:31 PM	5/12/2016 11:27:50 AM

Appendix R. Number of Instances and Sources of Codes. March 2017.

This table was exported from Nvivo. This shows the number of occurrences of each code in the data ("coding references") and the number of interviews these were spread across ("sources coded"). This table was exported in March 2017 when data analysis was complete. Please note some of these rows represent categories rather than codes.

Name	Number Of Sources Coded	Number Of Coding References	Created On	Modified On
Adapting and integrating mindfulness into life	5	13	11/4/2016 5:04:36 PM	11/19/2016 12:06:12 PM
Adjusting expectations	3	6	5/12/2016 11:38:09 AM	11/24/2016 2:30:26 PM
All contributions respected	9	19	5/15/2016 3:42:32 PM	11/24/2016 1:29:28 PM
Ambivalence about dropout	3	4	10/1/2016 1:48:45 PM	11/27/2016 2:46:21 PM
Attributing positive change to the group	10	20	5/14/2016 12:18:44 PM	11/24/2016 1:29:28 PM
Bringing voices into the open	6	7	9/23/2016 1:09:25 PM	11/24/2016 1:29:28 PM
Building bridges across difference	5	7	7/22/2016 2:22:50 PM	11/3/2016 4:34:54 PM
Callibrating clinic expectations	2	6	7/24/2016 10:49:52 AM	11/17/2016 3:43:03 PM
Catharsis	3	4	9/29/2016 11:55:04 AM	11/24/2016 1:29:28 PM
Clinic keeping everyone connected with the group process	4	44	5/14/2016 3:41:02 PM	11/18/2016 4:49:45 PM
Clinic responding to individual needs	9	14	4/14/2016 1:11:46 PM	11/18/2016 4:49:45 PM
Cognitive barriers	9	17	5/14/2016 11:23:33 AM	11/18/2016 7:03:45 PM
Collaborative spirit supporting motivation	8	10	9/24/2016 2:55:58 PM	11/27/2016 2:42:04 PM
Compassion between members	4	7	9/24/2016 2:43:26 PM	9/29/2016 11:51:05 AM
Compassion for group outliers building cohesiveness	3	7	9/26/2016 11:16:43 AM	11/18/2016 5:36:40 PM

Contact outside sessions showing the clinic cares	5	7	5/12/2016 11:45:27 AM	11/19/2016 12:25:54 PM
Continued contact after group dropout valued	3	10	9/24/2016 4:09:17 PM	11/18/2016 5:36:40 PM
Determined to maximise engagement in group sessions	6	9	5/14/2016 1:58:25 PM	11/24/2016 2:28:22 PM
Discovering Universality	7	29	5/12/2016 3:39:46 PM	12/1/2016 11:00:28 AM
Distressed by views of another group member	3	4	9/23/2016 12:59:49 PM	11/17/2016 12:48:33 PM
Doing it for family	2	2	9/24/2016 3:05:09 PM	11/24/2016 2:19:16 PM
Drawing hope from others coping	13	18	5/12/2016 4:33:19 PM	11/24/2016 1:29:28 PM
Experimenting with different coping strategies	4	6	5/12/2016 4:20:19 PM	11/26/2016 11:38:30 AM
Extrovert group members leading the way	2	5	10/23/2016 2:40:36 PM	10/23/2016 4:07:39 PM
Facilitators regulating outliers' behaviour	3	3	10/15/2016 12:40:32 PM	11/18/2016 5:36:29 PM
Familiar NHS location	3	3	10/23/2016 3:57:55 PM	11/27/2016 2:43:08 PM
Fear of being judged	9	17	4/14/2016 1:56:11 PM	11/27/2016 2:46:21 PM
Feeling abandoned by other services	7	19	5/14/2016 11:28:35 AM	11/24/2016 1:59:18 PM
Feeling different and not understood by other group members	3	3	5/14/2016 1:52:26 PM	11/17/2016 12:50:37 PM
Feeling disconnected from the group	2	2	5/14/2016 1:10:53 PM	11/17/2016 12:16:34 PM
Feeling held by caring clinic staff	7	8	5/15/2016 3:15:28 PM	11/18/2016 5:36:40 PM
Feeling safer in a small group	7	9	4/14/2016 1:42:28 PM	10/23/2016 4:43:55 PM
Feeling understood by the group	5	6	5/14/2016 12:10:22 PM	11/24/2016 1:29:28 PM
Feeling unsafe to meditate with relative strangers	5	7	5/15/2016 3:10:35 PM	11/27/2016 2:42:04 PM

Finding evidence to question voices	6	14	5/15/2016 3:33:36 PM	11/24/2016 1:29:28 PM
Finding time for group and home practice	5	10	4/14/2016 1:52:56 PM	11/18/2016 7:03:13 PM
Flowing with the clinic expectations	6	14	4/7/2016 4:40:12 PM	11/18/2016 6:45:41 PM
Gaining autonomy from voices	2	3	4/7/2016 4:56:49 PM	11/24/2016 12:49:46 PM
Giving it a go	5	32	5/12/2016 11:39:38 AM	11/24/2016 1:59:18 PM
Going backwards	8	13	11/17/2016 2:19:20 PM	11/24/2016 1:29:28 PM
Group and practice becoming part of routine	6	6	5/14/2016 11:49:05 AM	11/19/2016 12:06:12 PM
Group cohesiveness	7	13	9/24/2016 12:54:11 PM	11/24/2016 1:29:28 PM
Group rules creating safety	1	1	9/25/2016 12:41:48 PM	9/25/2016 12:41:48 PM
Group structure helping orientation	7	11	4/14/2016 1:24:30 PM	11/27/2016 2:35:43 PM
Hopefullness about a psychological model	2	5	10/15/2016 11:56:05 AM	11/24/2016 2:28:22 PM
Hopefulness about a group approach	5	6	7/22/2016 12:14:25 PM	11/26/2016 1:29:37 PM
Hopefulness from past experiences	11	28	4/7/2016 4:33:30 PM	11/27/2016 2:46:21 PM
Hoping to control voices	7	16	4/7/2016 4:51:12 PM	11/24/2016 2:28:22 PM
Hoping to feel normal	4	5	11/10/2016 12:24:23 PM	11/24/2016 2:28:22 PM
Hoping to get rid of voices	5	7	5/12/2016 11:37:00 AM	11/24/2016 2:28:22 PM
Hoping to understand voices	4	7	5/12/2016 11:36:31 AM	11/24/2016 2:28:22 PM
Hospitality and informal conversation	5	5	7/22/2016 2:33:14 PM	11/27/2016 3:13:15 PM
Humour taking the seriousness out of it	2	2	9/24/2016 6:42:39 PM	10/23/2016 4:04:39 PM

Inspiring others	3	3	5/15/2016 3:47:20 PM	11/24/2016 1:21:08 PM
Instability	3	5	7/24/2016 11:07:29 AM	11/17/2016 12:31:28 PM
Internalised hope	4	5	11/4/2016 5:25:57 PM	11/24/2016 11:54:01 AM
Internalised universality	4	6	11/4/2016 5:07:25 PM	11/24/2016 1:29:28 PM
Interpersonal anxiety	7	10	7/22/2016 2:46:28 PM	11/27/2016 2:46:21 PM
Interpersonal hopes	4	33	9/24/2016 3:42:50 PM	11/24/2016 1:59:18 PM
Interpersonal rewards	5	86	5/12/2016 12:13:05 PM	11/24/2016 1:29:28 PM
Interpersonal support to apply learning	3	24	5/12/2016 3:48:41 PM	11/19/2016 1:13:08 PM
Keeping up with group's shared knowledge.	4	5	5/12/2016 4:16:30 PM	11/18/2016 5:36:40 PM
Lacking activity	9	16	5/12/2016 11:50:47 AM	11/24/2016 2:28:22 PM
Learning from other group members	7	11	4/7/2016 4:59:34 PM	11/24/2016 11:56:12 AM
Learning to control voices and not fear them	3	4	5/12/2016 11:59:35 AM	9/24/2016 2:08:16 PM
Level of disclosure expected experienced as too threatening	1	2	10/15/2016 11:13:23 AM	11/17/2016 12:49:39 PM
Losing privacy	5	7	5/14/2016 1:02:48 PM	11/27/2016 2:46:21 PM
Loss of group belonging	7	14	11/17/2016 2:12:43 PM	11/24/2016 1:22:42 PM
Loss of outlet to discuss voices	6	11	11/17/2016 2:20:31 PM	11/24/2016 1:59:18 PM
Loss of witness to progress	2	3	11/17/2016 2:26:09 PM	11/18/2016 11:53:05 AM
Maintaining progress through support from other services	4	7	7/17/2016 11:41:35 AM	11/17/2016 1:37:34 PM
Making sense of voices psychologically	4	7	11/4/2016 5:10:27 PM	11/24/2016 1:29:28 PM

Making the work feel safe	4	30	7/22/2016 3:04:48 PM	11/27/2016 3:35:24 PM
Managing difference in the group	2	33	5/14/2016 3:43:42 PM	11/18/2016 4:49:45 PM
Mapping the group journey	9	13	7/22/2016 12:59:46 PM	11/24/2016 1:59:18 PM
Mindfulness aiding relaxation	7	9	9/24/2016 6:31:56 PM	11/24/2016 2:28:22 PM
Mindfulness relaxing people into the group	4	5	4/7/2016 5:15:30 PM	11/27/2016 2:43:08 PM
Mindfulness triggering difficult experiences	4	9	11/3/2016 4:04:35 PM	11/17/2016 12:46:10 PM
Mood interfering with engagement	5	6	5/12/2016 11:53:35 AM	11/19/2016 12:25:46 PM
Needing to change	5	7	5/12/2016 3:58:26 PM	11/24/2016 2:28:22 PM
Negative experience of mindfulness in-session	3	21	5/14/2016 1:08:19 PM	12/1/2016 10:47:54 AM
Nervous about new physical setting	5	8	4/7/2016 5:04:55 PM	11/27/2016 2:43:08 PM
New learning about voices	4	7	10/23/2016 3:23:12 PM	11/24/2016 1:29:28 PM
NHS location creating universality	1	1	9/25/2016 4:52:19 PM	9/27/2016 2:25:53 PM
No rigid formal rules	3	4	5/15/2016 3:11:39 PM	9/27/2016 3:20:11 PM
Noticing personal progress	6	9	11/3/2016 4:40:20 PM	11/24/2016 1:29:28 PM
Ongoing interpersonal support for learning	3	4	10/23/2016 4:46:50 PM	11/18/2016 11:29:12 AM
Others sharing suffering	8	9	5/14/2016 12:23:18 PM	11/24/2016 1:22:42 PM
Overcoming voices to engage with therapy	8	13	4/7/2016 4:56:04 PM	11/19/2016 1:13:08 PM
Pairing	3	5	5/14/2016 1:39:36 PM	11/18/2016 5:33:18 PM
Perceived problematic difference	6	15	5/14/2016 1:28:22 PM	11/18/2016 5:36:29 PM

Performance anxiety	4	7	4/7/2016 5:02:11 PM	11/4/2016 4:45:03 PM
Permission to leave the room if anxious	3	4	9/27/2016 3:20:17 PM	9/27/2016 4:22:15 PM
Persisting with new learning when frustrated	4	5	9/24/2016 3:27:50 PM	11/18/2016 5:36:40 PM
Phonecalls addressing practical problems	4	4	7/22/2016 3:02:49 PM	11/18/2016 5:36:40 PM
Physical health problems interfering with engagement	4	6	9/25/2016 3:09:03 PM	11/18/2016 5:36:40 PM
Physical location of group problematic	6	11	9/24/2016 3:49:04 PM	11/27/2016 3:13:15 PM
Physical prompts to practice	6	11	9/22/2016 2:22:36 PM	11/19/2016 12:03:58 PM
Planning the right time for practice	7	14	4/14/2016 1:45:42 PM	11/24/2016 1:29:28 PM
Pride in group participation	5	11	7/22/2016 1:48:21 PM	11/24/2016 1:29:28 PM
Reducing uncertainty to build engagement	1	25	7/22/2016 3:07:31 PM	11/27/2016 3:16:33 PM
Regulating own behaviour to fit in with group	2	6	7/10/2016 12:42:12 PM	9/28/2016 3:15:40 PM
Relaxed informal atmosphere	3	29	5/14/2016 11:28:58 AM	11/27/2016 3:42:59 PM
Relying on family support	3	3	9/22/2016 3:13:53 PM	11/19/2016 1:13:08 PM
Sealing over	5	9	9/25/2016 3:49:49 PM	11/24/2016 2:28:22 PM
Seeking universality	4	10	4/7/2016 4:32:47 PM	11/24/2016 1:59:18 PM
Settling in before working	5	6	9/13/2016 2:58:08 PM	11/4/2016 2:08:14 PM
Sharing difficulties with the group	8	11	9/23/2016 1:28:17 PM	11/19/2016 12:27:10 PM
Short-term commitment	5	9	11/17/2016 12:03:58 PM	11/24/2016 1:59:18 PM
Sizing up before jumping in	6	10	5/14/2016 3:55:02 PM	11/27/2016 3:13:15 PM

Socialising	6	9	4/7/2016 4:31:24 PM	11/24/2016 1:30:34 PM
Suspending judgement	4	5	4/7/2016 4:49:30 PM	11/24/2016 1:59:18 PM
Technical problems	5	7	7/24/2016 10:43:50 AM	11/17/2016 2:56:18 PM
Underlying commonalities driving respect	3	3	9/25/2016 3:21:46 PM	10/23/2016 4:05:17 PM
Understanding voices	2	7	4/14/2016 1:45:12 PM	9/28/2016 2:04:46 PM
Undesirable others	3	4	11/3/2016 4:18:55 PM	11/27/2016 2:46:21 PM
Universal responsibility to speak	5	9	4/14/2016 1:21:04 PM	10/1/2016 2:43:26 PM
Universality	5	7	5/14/2016 12:24:09 PM	11/17/2016 6:13:49 PM
Universality facilitating openness	7	13	5/12/2016 3:05:59 PM	11/24/2016 1:50:11 PM
Voices driving self-harm	3	4	5/14/2016 12:18:17 PM	11/24/2016 2:19:16 PM
Voices interfering with group engagement	11	26	5/12/2016 11:51:58 AM	11/19/2016 1:13:08 PM
Worrying about being rejected	3	5	9/25/2016 12:42:52 PM	11/10/2016 12:12:18 PM
Worrying about seeming crazy	2	3	4/7/2016 5:01:31 PM	11/3/2016 4:20:23 PM

Appendix S. Journal Submission Guidelines

Instructions for authors

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Appendix T. Summary of Research Findings for Participants.

Dear Participant

I'm writing to you because you took part in a research study of people's experiences of the voices clinic group therapy in *trust*

Firstly, thank you again for giving up your time to take part in the study. The results have already been used to produce a leaflet for people about to start the group. This is aimed at addressing some of the worries people might have about the group. We've based this on our conversations with participants in the study you took part in. We're now producing a hints and tips sheet for therapists of how best to help people engage with the group therapy, again based on our conversations with participants from this study. Our next aim is to publish the results in a journal so they can hopefully influence practice beyond *trust.*

The Study

We interviewed ten group members and three therapists about their experiences of engaging with the voices clinic group therapy. We then used a research method called grounded theory method (GTM) to analyse the interviews. GTM is used to build a theory from "qualitative data", like the interviews in this study. We hoped our theory would tell us something about what helps people engage with group therapy and what acts as a barrier.

The Results

These results are our best effort to summarise what people told us in the study. Not everything will apply to everybody, so you might find some of this isn't relevant to your own experience. However, you will hopefully find at least some of this familiar. You can see the results displayed in a diagram on the next page, but the diagram might make more sense if you read this first. We've included a selection of quotes from the people who took part on the page after that.

Description

We found that people invested in the group when they thought it would be useful for them and safe. If people didn't feel safe at any stage this sometimes led them to drop out. However, we found there was a "honeymoon" period at first, where people suspended their judgement, "gave it a go" and let the experience speak for itself.

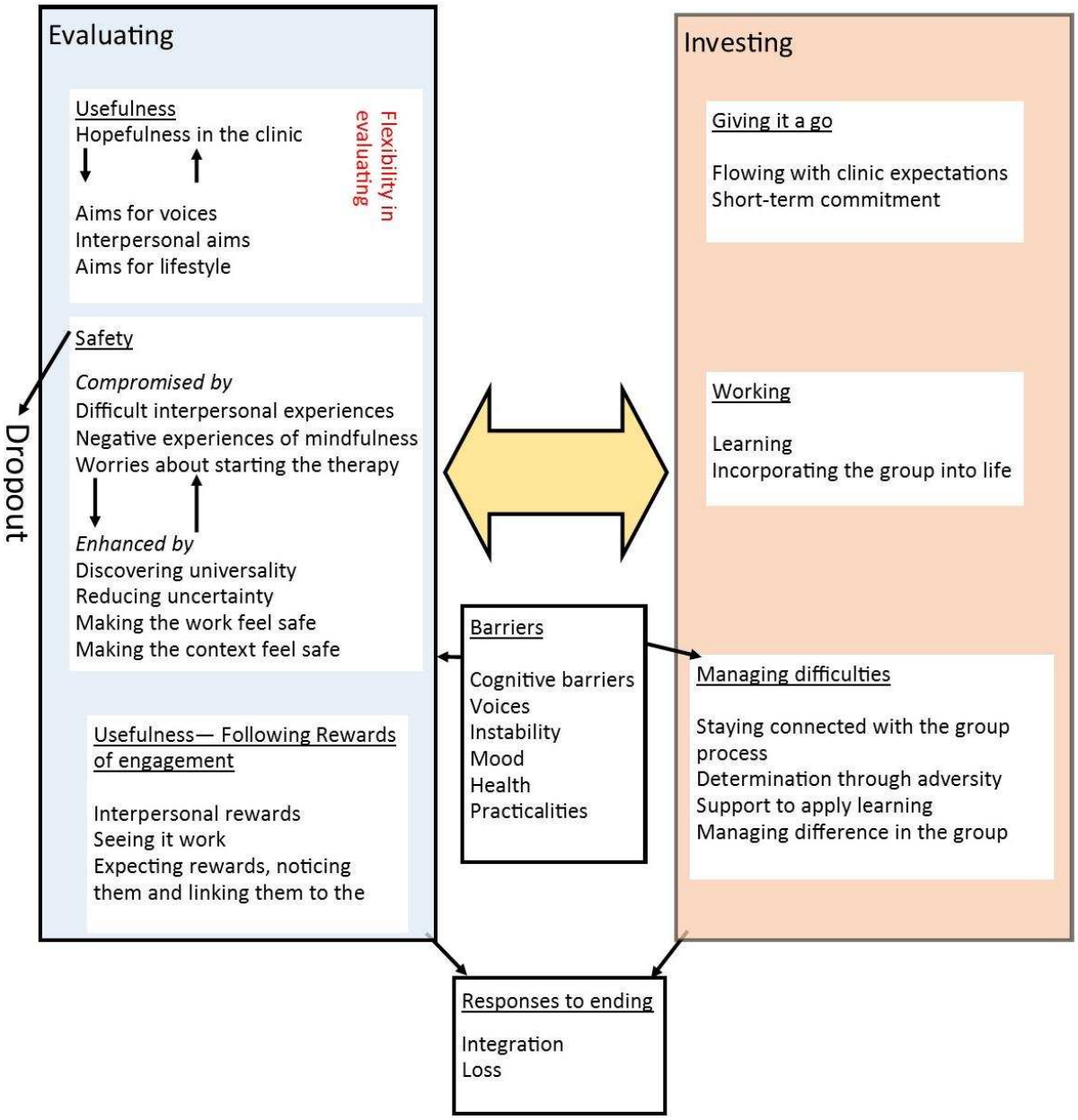
We found that feeling safe was people's main concern at first and later they became more interested in how useful the group was for their lives. Several people found the mindfulness scary, for different reasons. Some people felt able to stay despite this because they saw that other people in the group found it tough too. At first people anticipated how useful the group would be, based on their previous experiences of mental health services, and their confidence in the voices clinic and the mindfulness approach. Later people were able to see the group working for themselves or other people, and this generally kept them coming

back. When people began working in the group, by learning and incorporating the group into their lives, this led to different rewards. Some rewards were social– like knowing you aren't alone, seeing other people cope, feeling part of something important and feeling good about helping others. Other rewards were about seeing the group work – for example finding mindfulness useful to relax, or achieving your goals week on week and questioning just how powerful the voices really are.

Participants faced lots of barriers to engaging with the group. These included, sabotaging voices, memory or concentration problems, transport issues and anxiety or low mood. People overcame these in a number of ways, for example people often overcame anxiety by recognising that other people shared a lot in common with them. People felt able to come back after missing a session because phone calls with the voices clinic were useful and made people feel cared for.

Participants told us that they were very worried about going downhill after the group ended. When we spoke to a few people after finishing the group, we found that some of the benefits had been lost but people had built other benefits into their lives and their ways of thinking. For example the participants had kept up a mindfulness practice and had held on to the knowledge that other people were going through similar things.

Diagram


Evaluating
Usefulness
Hopefulness in the clinic
Aims for voices
Interpersonal aims
Aims for lifestyle
Flexibility in evaluating
Safety
Compromised by
Difficult interpersonal experiences
Negative experiences of mindfulness
Worries about starting the therapy
Enhanced by
Discovering universality
Reducing uncertainty
Making the work feel safe
Making the context feel safe
Dropout
Usefulness— Following Rewards of engagement
Interpersonal rewards
Seeing it work
Expecting rewards, noticing them and linking them to the
Investing
Giving it a go
Flowing with clinic expectations
Short-term commitment
Working
Learning
Incorporating the group into life
Barriers
Cognitive barriers
Voices
Instability
Mood
Health
Practicalities
Managing difficulties
Staying connected with the group process
Determination through adversity
Support to apply learning
Managing difference in the group
Responses to ending
Integration
Loss

Quotes

On starting the group

"I think just letting the experience just talking for itself rather than having too many preconceptions about how it's going to be was important for me".

"It was kind of straight in to the relaxation thing (…) Maybe the first time you just, I don't know, have a cup of tea and maybe talk about what's going to happen in the future (…) I just couldn't do it."

"From doing my one on one (…) because she was so good working with me, I thought (…) "oh the group's going to be really s--t because it's not one on one."

"I just throw myself in (because…) I have to do this. I have to. Because if I don't do this I'm going to be like this the rest of my life and I want to do things with my life."

On being with others in a group

"And even if I don't make it very well in the week I know that when I go to the group I've got that supportive atmosphere and that it doesn't feel like a hierarchy from them to us."

"You feel part of the group and because they've all got the same thing, it helps you to talk. Get all your thoughts out that you've bottled up."

"…just to be with other people that were experiencing the same thing, because it's not something you can just talk to anyone about really, is it?"

On mindfulness

I: "So anything that kept you attending the group? (…) P: Just knowing that the mindfulness was helping me and making a difference."

"I felt a bit self-conscious about doing (the mindfulness) but by the end of it I was able to sit and relax properly."

"There were a couple of people who didn't really like mindfulness (…) So it felt much easier for me to say, "yea I didn't really get on with it."

"I just felt really awkward because everything else was doing what they were supposed to be doing and I wasn't."

"It just makes me feel like I can't sit there concentrating on it properly because I feel too agitated so I- but when I'm a little bit calmer, when I've calmed down a bit I'm able to sit down and listen to it properly."

On overcoming voices

"They're helping you to understand that the voices can't harm you and you can resist what they're saying."

"At first I thought it would maybe get rid of it (the voices) altogether (…) but I've learnt that they can't get rid of it altogether but they help you to understand it."

"*Sometimes when the voices tell me something I question them now. Because I think, "yea the therapist was right, he says "you need to have evidence"."*

"They always have it on the wall. What we did the previous week. (…) So we all know, (…) "the voices are not true because we did go for a coffee or someone went swimming."

"I managed to go but it took me about four hours to get out of the house and go but I got there in the end. So it just takes a lot of energy to keep fighting them."

On the group ending

"What about all I've done, going out and everything, making big steps. What am I going to do? If it stops (…) what if I go downhill?"

Thoughts after the group ended

"It sounds really depressing to be thankful that others are going through the same thing as yourself (…) but I am thankful that there are those people."

"I think it's important that people are aware that it's not just one exercise but that there are lots of different ways you can practice mindfulness. It doesn't have to be something you have to listen to on an mp3 player."

"So then I lie in bed and put the mindfulness thing on and I can feel it calm me down because it's quite relaxing."

"I suppose I've still held on to the fact that there are people who suffer with voices but they can really get on with their lives and really deal with them. (…) So yea, that's been really positive."

With thanks

Hopefully some of the results fit with your own experience of the group. Thank you again for taking part, we're confident it will help us improve our services for future group members.

Yours Sincerely

Ciaran McHale
Chief Investigator for the group engagement study

Appendix U. Letter to Research Ethics Committee and Trust R&D Department to Feed Back the Study Results.

Date: 23rd March 2017

REC reference number:

Study Title: Building a grounded theory of engagement and disengagement in group person based cognitive therapy.

Dear [chair of REC/ R&D manager],

I am writing to inform you that the above research project has now been completed.
The research was conducted as originally intended and the research objectives were achieved.

Summary of research

Objectives: The National Institute for Clinical Excellence (NICE) recommends that Cognitive Behavioural Therapy for psychosis (CBTs) should be offered to people distressed by psychotic symptoms (NICE, 2014). However, access to CBTp remains limited, partly due to a shortfall in trained therapists. One way to improve access is to deliver CBTp in a group format. The evidence for group CBTp's effectiveness is equivocal. Person Based Cognitive Therapy (PBCT) offers an alternative approach based on third-wave principles of acceptance of psychotic experiences (Chadwick, 2006). An evaluation of group PBCT found significant improvements in well-being, distress, control of and dependence upon voices following therapy (Dannahy et al., 2011). PBCT is a promising group treatment for distressing psychotic experiences, but fostering engagement in groups is difficult (Wierzbicki & Pekarik, 1993) and unlike individual therapy, poor group attendance impacts on others (Gellatly & Luchak, 1998; MacNair&Corazzini, 1994). Given this, research that guides services in improving engagement is vital. Grounded theory method (GTM) is a qualitative methodology well suited to investigating complex, dynamic social processes (Uqruhart, 2012) such as group engagement. GTM can also be employed to build theory and generate testable hypotheses in areas like engagement in group PBCT that are currently poorly understood. Given this, and the current need for more group therapies for distressing psychotic symptoms, this study aimed to build a grounded theory of engagement in group PBCT.

Methods: Ten patients and three therapists were interviewed about their experiences of engagement in group PBCT, using a semi-structured interview schedule. Two participants were interviewed on a second occasion. The data were generated and analysed using methods outlined in Corbin & Strauss (2008). Interviews and data analysis ran concurrently, theoretical sampling was employed to enrich the theory and constant comparison was used to develop categories and their relationships with one another.

Results: Overview of the model.

Categories are presented here in bold. The theory hypothesises a recursive process of **investing** in the group therapy and **evaluating** it in terms of its **usefulness** and **safety**. If its **safety** is **evaluated** to be lacking at any stage, this may lead to participant **dropout**. That

said, the initial period of group engagement is often characterised by **flexibility in evaluation** and an **initial short-term commitment** i.e. **giving it a go.**

Investing and **evaluating** dovetail over time and do not follow a strict sequence. However, a few rules of thumb seem to apply. Firstly, **safety** is more important to participants in earlier stages. Secondly, participants initially **evaluate** the **usefulness** of the group on relevant past experiences and their **hopefulness in the clinic** approach. Later they use direct experiences of **seeing it work** for themselves and/or other group members. **Working** in the group, by **learning** and **incorporating the group into life**, can lead to various **rewards of engagement**, including **interpersonal rewards** and **seeing it work**. If group participants **expect rewards, notice them and link them to the group**, this particularly motivates ongoing **investment**.

Participants face various **barriers** to fruitful group engagement. **Managing these difficulties** can be achieved in a number of ways. However, these **barriers** can significantly impair fruitful engagement and impact negatively on **evaluations** of the group, particularly its **safety,** and thereby precipitate dropout. Participants' **responses to (group) ending** are various. Participants **integrate** some benefits into their lives in a lasting way, while others are **lost**.

Categories and Sub-Categories of a Model of Engagement in Group PBCT.

Categories	Sub-categories
A. Giving it a go	1. Giving it a go
B. Safety	2. Worries about starting the therapy
	3. Making the context feel safe
	4. Reducing uncertainty
	5. Making the work feel safe
	6. Relaxed informal atmosphere
	7. Negative experiences of mindfulness
	8. Difficult interpersonal experiences
	9. Discovering universality
C. Working	10. Learning
	11. Incorporating the therapy into life
D. Usefulness	12. Aims for voices
	13. Interpersonal aims
	14. Hopes for life
	15. Hopefulness in the clinic

	16. Flexibility of evaluation
	17. Useful learning
	18. Interpersonal rewards
	19. Expecting rewards, noticing them and linking them to the therapy
E. Barriers	20. Barriers
F. Managing difficulties and renewing commitment	21. Managing difference in the group
	22. Interpersonal support to apply learning
	23. Determination through adversity
	24. Staying connected with the group process
G. Responses to ending	25. Integration
	26. Loss

Section D Conclusions:

Arrangements for publication/dissemination

It is intended that findings will be submitted for publication in "Psychotherapy Research" journal. At a service level, findings have already been disseminated in the form of a leaflet that has been developed to orientate and reassure people who are about to begin group therapy and a hints and tips sheet for therapists.

Feedback to participants:

A brief summary of findings has been posted out to research participants. Participants have been offered contact details for the chief investigator should they wish to feed back on the findings.

Yours sincerely,

Ciaran McHale

Appendix V. Participant characteristics – unabridged table.

* This has been removed from the electronic copy*

Appendix W. Group leaflet

What have others gained from the groups?

"We actually are a nice little group. We like each other and we're safe in that group." (Dexter)

"It got to the point where I was sometimes sleeping in the car because the voices were chasing me around the house (but after doing the group) the voices are better than they were. I try very hard to use the mindfulness practices (Debbie)

Common concerns before starting the group

Group members have told us about their concerns before starting past groups and how they overcame them. Here are a few examples…

"Yeah. I didn't know if I would stick to it. Because my voices make it difficult for me. I have trouble waking up early but I've only missed one session." (Ryan)

"I was worried about getting on with people…just some worries about feeling accepted. I think I just tried it. Just letting the experience talk for itself." (James)

"I'm not really a people person but it's not a big group, it's just a small group and I can handle that. (Ryan)

Any questions before the group starts?

Please feel free to give us a call on ***xxxxxxxx*** *and ask to speak to someone in the voices clinic. We'll help as best we can.*

Where will the group take place?

Anonymised

Who will facilitate the group?

Anonymised

Voices Clinic

Group Therapy

Anonymised

Starting 21st February 2017

Information

What can I expect from the group?

The group will run for twelve sessions at the same time each week. The sessions last for one and a half hours, with a break in the middle for a cup of tea and a chat. You are also welcome to leave the room if you need to. There will be up to nine people in each group (normally 6 or 7).

The groups follow the same structure each week. We start with a mindfulness practice, we talk about our experiences of the practice as a group and then we have a break. In the second half we focus on Cognitive Behaviour Therapy (CBT) for voices.

What is mindfulness?

Mindfulness isn't a religious practice and it doesn't involve chanting "ummmmmm"! Mindfulness is a way of exploring our experience in the present moment with curiosity and kindness. Research has shown that this can be a helpful way of overcoming distressing voices.

Experiences of Mindfulness

We asked James, who attended a previous group, what kept him coming back:

"Just knowing that the mindfulness was helping me and making a difference." (James)

Anonymised

Paul had worries about the mindfulness:

"I felt a bit self-conscious about doing it but by the end of it I was able to sit and relax properly" (Paul).

What is CBT?

CBT involves exploring the thoughts we have about voices and ourselves. For example: How powerful are my voices? Do they have bad intentions for me? How much control do they have over me? How much control do I have? CBT helps us re-evaluate some of these thoughts. It can help you feel less distressed by the voices and build self-esteem

Experiences of CBT

"They're helping you to understand that the voices can't harm you and you can resist what they're saying" (Paul).

"When the voices tell me something I question them now. Because I think, "yea the group facilitator's right, he says "you need to have evidence", that's not right what the voices are telling me". So now I question the voices a little bit more." (Dexter)

Anonymised

What have others gained from the groups?

"To hear about other people's techniques, about what they use to help themselves, it gives me ideas to try, and even if I don't feel very well in the week I know that when I go to the group I've got that supportive atmosphere." (Debbie).

"You feel part of the group and because they've all got the same thing, it helps you to talk. Get all your thoughts out that you've bottled up." (Paul).